# Administration of Mental Health Services by Medicaid Agencies

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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# Contents

# Tables

# Figures

# Executive Summary

State Medicaid agencies are playing an increasing role in funding, managing, and monitoring public mental health services in States, reflecting the steady growth over the last three decades in the share of public mental health services funded by Medicaid. Yet relatively little is known on a State-by-State basis about how Medicaid agencies are exercising their responsibilities for mental health services. The survey described in this report begins to fill that gap.

This report presents the results of hour-long telephone interviews with State Medicaid directors or their designees in all 50 States and the District of Columbia that explored how State Medicaid agencies are addressing the organizational, funding, policy, management, and data issues that arise from their increased and often shared responsibilities for mental health services.

## Growth in Medicaid Funding of Mental Health Services

The Medicaid share of total national mental health spending (both public and private) rose from 19 percent in 1991 to 27 percent in 2001, while non-Medicaid State mental health spending dropped from 27 percent of total national mental health spending to 23 percent during the same period. The Medicaid share of total State mental health spending is projected to rise from its current level of more than half to as much as two-thirds by 2017. The shift toward greater Medicaid funding of mental health services has resulted in part from the movement of mental health services from institutional settings, where Medicaid funding is limited, to community settings, where it is more readily available. It also reflects efforts by States to obtain Federal Medicaid funding for services that previously were funded entirely with State or local dollars.

## Findings

States have taken varying approaches in expanding Medicaid to cover mental health services. While Federal law requires that the Medicaid agency must retain ultimate authority over all aspects of the Medicaid program, States may delegate responsibility to other State agencies or to private contractors for activities such as certifying and enrolling providers, defining covered services and setting rates, administering payments to providers, and collecting and reporting data. Some States have chosen to have the Medicaid agency retain full administrative responsibility for all mental health services if they are funded with Medicaid dollars and provided to Medicaid enrollees, while other States have chosen to share those responsibilities in various ways with mental health or other agencies in the State. As a result of this flexibility, the administration of Medicaid mental health services varies considerably across States.

- Organizational Structure. In most States, the Medicaid director reports directly to the Governor or is separated by only one reporting level. State Medicaid and mental health agencies are within the same umbrella agency in 28 States, most commonly health and human services, and are separate in 23 States.
- Funding. In 26 States, the State match for Medicaid mental health services comes at least partially from a different source than the State general fund, most frequently from counties or other local sources. In 32 States, the State match comes at least partially from the mental health agency.
- Providers. The majority of States restrict Medicaid providers of mental health services to those with a mental health designation, and 22 States delegate the enrollment of mental health providers to the mental health agency. Twenty-six States reported that at least some Medicaid mental health services or populations are covered through behavioral health organizations or administrative services organizations.
- Data and Reporting. Forty States reported that their Medicaid agencies produce formal reports containing discrete data on Medicaid mental health utilization or expenditures, and in 27 States the mental health agency produces such reports. Most States allow the mental health agency access to the Medicaid Management Information System (MMIS), but very few States have linked client-level data.
- Collaboration. Slightly more than half the Medicaid respondents said that Medicaid and mental health agencies collaborate frequently through internal and external meetings, public reports, or presentations to the legislature. Medicaid and mental health agency collaboration tends to be highest in States where both agencies are in the same umbrella agency and lowest where they are in separate agencies and where the mental health agency has authority to set some Medicaid rates.
- Authority. Medicaid agency authority over mental health funding, provider rate setting, and data appears to be highest when Medicaid and mental health agencies operate separately and there are limited opportunities for Medicaid to make use of the public mental health system, while Medicaid agency authority tends to be lower when the agencies are part of the same umbrella agency and the public mental health system has the capacity to administer Medicaid services.

# I. Introduction

State Medicaid agencies are playing an increasingly important role in the funding and administration of State mental health services. While the increase in Medicaid funding for mental health services in recent decades and the major factors that account for it have been well described, less is known about how State Medicaid agencies are exercising their growing responsibilities for mental health services. Accordingly, the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned a telephone survey of State Medicaid agencies aimed at learning more about how these agencies administer Medicaid-funded mental health services. The survey asked questions about how Medicaid agencies are organized, what their relationships are with State mental health agencies, and how funding, provider, data, and reporting issues are handled. The results of the survey are summarized in this report.

## A. Background and Context

In 2001, Medicaid spending for mental health care accounted for 27 percent of total mental health expenditures by all public and private payers combined, up from 19 percent in 1991 and 14 percent in 1971. Other State and local spending on mental health (including that provided through mental health agencies) dropped from 30 percent in 1971 to 27 percent in 1991 and 23 percent in 2001 (Mark et al., 2005). Medicaid now funds more than half of all mental health services administered by States, and could account for two-thirds of such spending by 2017 (Buck, 2003). Between 8 and 12 percent of all Medicaid dollars are spent on mental health services (Mark, Buck, Dilonardo, Coffey, & Chalk, 2003).

The trend toward greater Medicaid funding of mental health services began soon after the Medicaid program was enacted in 1965, as mental health care shifted from institutional to community settings, and as Medicaid began taking over more of the financing role held by State or county mental health authorities before 1970. Between 1970 and 1980, the number of inpatient psychiatric beds in State and county hospitals fell by more than half as cases and costs were shifted to Medicaid-reimbursable settings in the community (Frank & Glied, 2006a, 2006b).

Increased Medicaid funding of mental health services has substantially changed the State mental health policy landscape. Federal Medicaid requirements have reduced the flexibility States previously had to shape mental health services and their delivery, and pressures to use State mental health dollars to obtain additional Medicaid funding have sometimes limited the ability of mental health agencies to provide services for those not eligible for Medicaid (Frank, Goldman & Hogan, 2003).

### *1. Shift from Institutional to Community Services*

As noted above, a major reason for the shift toward Medicaid funding of mental health services is the trend during the past quarter of a century away from providing mental health services in institutions, where Medicaid funding is very limited, toward providing services in the community, where Medicaid funding is more readily available. This movement to deinstitutionalize mental health services is consistent with Federal policy on the delivery of care to persons with mental illness. The President's New Freedom Commission on Mental Health identified delivering care in an integrated setting, with "services in communities rather than institutions," as one of the hallmarks of a "transformed system" for treating mental illness. "[T]he Nation must replace unnecessary institutional care with efficient, effective community services that people can count on," the Commission said. "It needs to integrate programs that are fragmented across levels of government and among many agencies" (New Freedom Commission on Mental Health, 2003, pp. 3–4).

### *2. Impact on Financing*

White and Draper (2004) identify this shift toward community care as sparking the trend toward increased Medicaid funding for mental health services. Since Federal Medicaid regulations prohibit funding services for adults between 22 and 64 years of age in institutions for mental diseases (the IMD exclusion), deinstitutionalization has resulted in many previously ineligible persons becoming eligible to receive Medicaid-funded services. Many States, facing budget shortfalls, looked to Medicaid as a way to save money by obtaining a Federal match for services that formerly had been covered solely by the State general fund. Between 1997 and 2001, State match and Federal Medicaid funds for mental health services increased 69 percent, while State general funds rose by only 19 percent (National Association of State Mental Health Program Directors Research Institute [NRI], 2004). The influx of Medicaid funding has given State and Federal Medicaid agencies more overall influence within State public mental health systems (Frank et al., 2003). There has, however, been no systematic State-by-State analysis of the characteristics of this influence, from the Medicaid agency perspective, with respect to the policy-setting process, funding arrangements, or data sharing. (As noted below, several surveys in recent years have looked at these issues from the perspective of State mental health agencies.)

### *3. Impact on Organizational Structure*

The increasing role of Medicaid in providing mental health services also may influence the structure of State agencies, and it may affect any reorganizations States undertake. In 2003, a study of State restructuring efforts found that 18 of the 22 States undergoing changes were consolidating health (and sometimes human services) agencies, in many cases under one umbrella agency (VanLandeghem, 2004). The rationale for many of these restructurings was to move away from defining State agencies by services and toward defining them by the populations they served. Of the 15 State restructuring initiatives that affected Medicaid in 2003, 4 States proposed elevating the Medicaid agency to a more prominent place within existing health structures (VanLandeghem, 2004).[1] The move toward more consolidated health structures,

[1] The report did not say whether any of the reorganizations proposed elevating mental health agencies.

with Medicaid playing a more prominent role, is consistent with the enhanced role Medicaid has played in funding mental health services. In 2003, 21 States reported having an umbrella agency that included both Medicaid and the mental health authority, while 15 States had independent mental health agencies (VanLandeghem, 2004). To the extent that the trend toward mental health services being funded by Medicaid continues, restructurings may result in more mental health authorities being co-located along with Medicaid within larger health structures.

#### *4. Impact on Consumers*

The 2003 New Freedom Commission report noted that the complex mental health system overwhelms many consumers and that "fragmentation is a serious problem at the State level":

> State mental health authorities have enormous responsibility to deliver mental health care and support services, yet they have limited influence over many of the programs consumers and families need. Most resources for people with serious mental illness (e.g., Medicaid) are not typically within the direct control or accountability of the administrator of the State mental health system. For example, depending on the State and how the budget is prepared, Medicaid may be administered by a separate agency with limited mental health expertise. Separate entities also administer criminal justice, housing, and education programs, contributing to fragmented services (New Freedom Commission, 2003, p. 3).

## B. Survey of State Medicaid Directors

This report provides, from the perspective of State Medicaid agencies, a State-by-State look at some of the effects of increased Medicaid funding and influence on the provision of mental health services. It is based on the results of a telephone survey of Medicaid directors or their designees in all 50 States and the District of Columbia.

#### *1. Methodology*

The telephone survey was conducted between July 2005 and February 2006.[2] This hour-long, in-depth interview, consisting of both closed- and open-ended questions, was designed to gather the Medicaid perspective on five domains: organizational structure, Medicaid mental health policy infrastructure, Medicaid mental health services and spending, Medicaid mental health providers, and data use and reporting. Given their busy schedules, those respondents who wanted to complete the closed-ended questions prior to the telephone interview could request and receive a copy of the survey instrument in advance.

The response rate was 100 percent, with five States electing to complete the survey entirely in writing rather than through a telephone interview. In 22 States, the respondents were the heads of the Medicaid agency; in 7 States the respondents reported directly to the Medicaid directors; in 15 States there were one or more levels between the respondents and the Medicaid directors; and in 6 States the Medicaid directors designated respondents in the State mental health agency.[3] On average, the respondents had held their current positions for 4 years and had been involved in their States' or any

[2] Three Medicaid director interviews were conducted in late 2004, as part of a pretest of the survey instrument.

[3] In one State, the survey was filled out and returned via fax without respondent identification.

States' Medicaid program for 11 and 16 years, respectively.[4]

Once the data collection was complete, responses to the closed-ended questions in each State were compiled into 10 tables and sent to each respondent and Medicaid director to allow States the opportunity to correct any inaccuracies or nonresponses. Each State received only the data from that State. Thirty-eight States provided corrections or confirmed the accuracy of the data in the tables.

### *2. Limitations*

The survey represents a snapshot at a point in time. The ways in which Medicaid agencies exercised their responsibilities for mental health services in the last half of calendar year 2005, when most of the interviews were conducted, were often different in prior years and will change in the future in many States because of gubernatorial elections, new agency leadership, reorganizations, and new State priorities. The survey represents primarily the Medicaid agency perspective, although in some instances Medicaid directors designated respondents from the State mental health agency, instead of or in addition to Medicaid agency respondents.

The survey took 7 months to complete, reflecting the difficulty in scheduling 1-hour interviews with high-level State officials and their staffs who have many other, often unpredictable, demands on their time, especially during legislative sessions.

Respondents varied in their ability to answer all of the questions in the survey and in the extent to which they consulted with others in the Medicaid and mental health agencies to obtain the information they needed to respond. As noted above, the Medicaid director was not the respondent in every State. Other respondents may not have had the broad perspective of a Medicaid director, although they may have had more specialized knowledge about particular issues. Midlevel managers, for example, are not likely to have firsthand knowledge of what is discussed in meetings between agency directors, with umbrella agency heads, or with the Governor. Conversely, Medicaid directors may not know about all of the day-to-day interactions that may occur between Medicaid and mental health agency staff, or about the details of data collection and use or provider licensing and certification.

In addition, with only an hour to speak to each respondent, there were limits on the detail that could be obtained and the follow-up questions that could be asked. For example, while the survey requested some information about the use of Medicaid managed care, the complexity and variety of managed care programs used by State Medicaid agencies made it difficult to gather systematic and consistent State-by-State information on these programs.

## C. Overview of the Rest of the Report

Chapter II presents a summary of the findings for all States, focusing on the organizational structure for the administration of Medicaid mental health services, how issues related to funding and providers are handled, and data collection and reporting. The chapter includes State-by-State tables that summarize State responses to most of the questions in the survey, as well as graphs that highlight some of the patterns in the responses. It also includes excerpts from the interviews and dis-

[4] In States where more than one respondent was on the call, only the experience of the most senior respondent was used for the data reported in this paragraph.

cussions of some issues raised in response to open-ended questions.

Chapter III continues the presentation of results for all States, focusing in particular on the relationships between Medicaid and mental health agencies and factors that facilitate or may impede Medicaid and mental health collaboration.

Chapter IV looks in more detail at some specific types of States: those with relatively higher and lower levels of collaboration between the Medicaid and mental health agencies, and those in which the Medicaid agency either retains a relatively high degree of authority over Medicaid-funded mental health services or shares that authority to a relatively high degree with the mental health agency. The chapter examines how these four different types of States deal with common issues, such as Medicaid managed care programs that cover mental health services.

Chapter V summarizes the report and provides some conclusions.

Appendix A includes additional State-by-State tables. Appendix B lists the experts on the Medicaid Mental Health Services Panel.

# II. National Overview: Organizational Structure, Funding, Providers, and Data

This chapter provides a national overview of how State Medicaid agencies administer Medicaid-funded mental health services, focusing specifically on organizational structure, funding, services, providers, managed care, and data sharing and reporting. Chapter III describes ways in which Medicaid agencies interact with mental health and other State agencies in administering Medicaid-funded mental health services and developing policy. The tables provide State-level detail from the survey on these issues, and the graphs highlight some national patterns. Issues highlighted by interviewees in response to open-ended questions, such as the impact of reorganizations, are also discussed.

## A. Organizational Structure

### *1. Background*

a. State Medicaid Agencies

**Medicaid Program Overview.** The Medicaid program is a joint Federal-State program that provides health care to low-income Americans in all 50 States and the District of Columbia. The Federal Government provides from 50 to 76 percent of the funding for Medicaid, depending on State income levels, and State and local governments provide the rest. States retain primary authority over how the program is administered, but they must follow certain Federal guidelines in order to continue receiving Federal funding. These guidelines specify which groups may and must be covered by Medicaid and which services may and must be covered. States are required to cover a core set of medical services for all Medicaid beneficiaries, such as physician visits, inpatient and outpatient hospital services, and certain screening services for children. States have the option to cover additional services if they choose, including mental health services such as inpatient psychiatric services for children and the elderly; clinical services provided by a psychiatrist, psychologist, or social worker; or outpatient rehabilitative services.[5]

[5] However, States cannot receive Federal matching funds for services provided to adults aged 22 to 64 in institutions for mental diseases.

**"Single State Agency" Requirement.** Federal law and regulations require that there be a "single State agency" that administers or supervises the administration of the State Medicaid program. Day-to-day responsibility for many aspects of the Medicaid program may be delegated to other State agencies or administered by private contractors, as long as the Medicaid agency retains ultimate authority and responsibility.[6] Other State agencies or contractors, for example, may share responsibility for certifying and enrolling providers, defining covered services and setting rates, administering payments to providers, collecting and reporting data, and determining the eligibility of applicants and enrolling them into the program.

With respect to mental health services, a State may choose to have the Medicaid agency retain full responsibility for all such services if they are funded with Medicaid dollars and provided to Medicaid enrollees, or share those responsibilities in various ways with mental health or other agencies in the State. As a result of this flexibility, the organizational structure of the Medicaid agency and other State agencies that have responsibility for administering some functions of Medicaid may vary considerably across States.

**Medical Care Advisory Committee.** In addition to the "single State agency" requirement noted above, Federal regulations require that there be a Medical Care Advisory Committee to advise the State Medicaid director about health and medical care services.[7] The membership of this committee must include the director of either the public welfare department or the public health department, whichever does not include the Medicaid agency. There is no explicit requirement for State mental health agency representation.

**Data Requirements.** State Medicaid agencies have also been required since 1999 to submit data to the Federal Government on services provided to beneficiaries and amounts paid to providers in uniform electronic formats through the Medicaid Statistical Information System (MSIS).[8] Medicaid agencies have been required since the mid-1970s to have a standardized and mechanized claims processing and information retrieval system, called the Medicaid Management Information System (MMIS).

### b. State Public Mental Health Systems

There are many State agencies that may provide mental health services, such as the agencies responsible for disability services, education, juvenile justice, or corrections, but the dominant agency for administering services in the public mental health system in most States is the State mental health agency. Mental health agencies are usually responsible for operating State psychiatric hospitals and funding community mental health centers. In some States, the mental health agency is also responsible for providing services related to substance abuse or developmental disabilities. While State mental health agencies receive some Federal money in the form of Community Mental Health Services Block Grants,[9] the majority of funding comes from the State. Accordingly, the mental health agency generally has more freedom than the Medicaid agency in deciding what populations to cover, what services to provide, and how those services are administered.

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[6] Social Security Act, Section 1902(a)(5), and 42 Code of Federal Regulations (CFR) sec. 431.10.

[7] 42 CFR sec. 431.12.

[8] Social Security Act, Section 1903(r)(1)(F).

[9] Authorized by Title XIX of the Public Health Services Act and administered by SAMHSA.

States also have more flexibility in choosing the organizational structure of the agency or agencies that provide mental health services, since there is no Federal "single State agency" requirement as there is in Medicaid. A number of States have more than one mental health agency. States that receive Federal mental health formula grants are required to have a State Mental Health Planning Council that includes a representative of the State Medicaid agency.[10] State mental health agencies are not required to provide the kind of uniform and detailed data to the Federal Government on enrollment, services, and provider payments that Medicaid agencies must provide.

### *2. Survey Results*

The majority of States[11] have one State-level Medicaid agency and one State-level mental health agency (Table 1). Seven States reported more than one State-level mental health agency, in most cases due to a separation of the child and adult mental health systems.[12] In a number of States, including California, Iowa, Ohio, and Utah, county mental health agencies play a large role in administering mental health services and working with the State Medicaid agency.

States reported that the Medicaid and mental health agencies are under the same umbrella agency in 28 States, and are separate agencies in 23 States. Within the umbrella agencies, some States arrange Medicaid and mental health as parallel or sister agencies. In a few States, the umbrella agency itself is the designated "single State agency" for Medicaid, and the mental health agency is a division within it. More than half of the umbrella agencies (17) are combined health and human services agencies, while 7 States have umbrella agencies that deal with human services only, and 4 States have umbrella agencies that deal with health only. A number of States where the two agencies are separate reported that the mental health agency was a cabinet-level agency of its own, or that it reported to its own appointed board.

In the vast majority of States, two or fewer reporting levels separate the Medicaid director and the Governor (Figure 1). There are only 5 States where the Medicaid director reports directly to the Governor; in 25 States, one formal organizational level separates them, while in another 19 States, they are separated by two organizational levels. In only two States are there three or more levels between the Medicaid director and the Governor.

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[10] 42 USC sec. 300x-3(c)(1)(A)(ii).

[11] In this report, the District of Columbia generally is referred to as a State when the numbers of States in various categories are reported.

[12] Connecticut, Delaware, Hawaii, Montana, Nevada, New York, and Rhode Island reported more than one mental health agency. For the remainder of this report, the adult mental health agency or the agency identified by survey respondents as the main State-level mental health agency is referred to as the State mental health agency.

## Table 1: Organizational Structure

| *State* | *Medicaid and mental health agencies under the same umbrella agency* | *Name of the umbrella agency* | *More than one mental health agency* | *Reporting levels between the Medicaid director and the Governor*[1] | *Interagency agreement or memorandum of understanding between the Medicaid and mental health agencies* |
|---|---|---|---|---|---|
| Total | 28 | | 7 | | 34 |
| Alabama | No | | No | None | Yes |
| Alaska | Yes | Department of Health and Social Services | No | Two | No |
| Arizona | No | | No | None | Yes |
| Arkansas | Yes | Department of Health and Human Services | No | Two | NR |
| California | Yes | Department of Health and Human Services | No | Three | Yes |
| Colorado | No | | No | Two | Yes |
| Connecticut | No[2] | | Yes | Two | Yes[5] |
| Delaware | Yes[4] | Department of Health and Human Services | Yes | One | Yes[6] |
| District of Columbia | No | | No | Two | Yes |
| Florida | No | | No | One | Yes |
| Georgia | No | | No | Two | Yes |
| Hawaii | No[2] | | Yes | One | Yes[5] |
| Idaho | Yes | Department of Health and Welfare | No | None | NR |
| Illinois | No | | No | Two | Yes |
| Indiana | Yes | Family and Social Services Administration | No | One | Yes |
| Iowa | Yes | Department of Human Services | No | One | No |
| Kansas | No | | No | One | Yes |
| Kentucky | Yes | Cabinet for Health and Family Services | No | Four or more | Yes |
| Louisiana | Yes | Department of Health and Hospitals | No | Two | Yes |
| Maine | Yes | Department of Health and Human Services | No | Two | No |
| Maryland | Yes | Department of Health and Mental Hygiene | No | Two | No |

See notes at end of table.

*Continued*

Table 1: Organizational Structure, *continued*

| *State* | *Medicaid and mental health agencies under the same umbrella agency* | *Name of the umbrella agency* | *More than one mental health agency* | *Reporting levels between the Medicaid director and the Governor*[1] | *Interagency agreement or memorandum of understanding between the Medicaid and mental health agencies* |
|---|---|---|---|---|---|
| Total | 28 | | 7 | | 34 |
| Massachusetts | Yes | Executive Office of Health and Human Services | No | One | Yes |
| Michigan | Yes | Department of Community Health | No | Two | No |
| Minnesota | Yes | Department of Human Services | No | One | No |
| Mississippi | No | | No | None | Yes |
| Missouri | No | | No | One | Yes |
| Montana | Yes[3] | Department of Public Health and Human Services | Yes | One | No[7] |
| Nebraska | No | | No | One | Yes |
| Nevada | Yes[3] | Department of Health and Human Services | Yes | One | Yes[5] |
| New Hampshire | Yes | Department of Health and Human Services | No | One | No |
| New Jersey | Yes | Department of Human Services | No | Two | No |
| New Mexico | No | | No | One | Yes |
| New York | No | | Yes | Two | Yes |
| North Carolina | Yes | Department of Health and Human Services | No | One | Yes |
| North Dakota | Yes | Department of Health and Human Services | No | One | Yes |
| Ohio | No | | No | One | Yes |
| Oklahoma | No | | No | Two | Yes |
| Oregon | Yes | Department of Human Services | No | One | No |
| Pennsylvania | Yes | Department of Public Welfare | No | One | No |
| Rhode Island | No[2] | | Yes | Two | Yes[5] |
| South Carolina | No | | No | None | Yes |
| South Dakota | No | | No | Two | No |

See notes at end of table.

*Continued*

Table 1: Organizational Structure, *continued*

| *State* | *Medicaid and mental health agencies under the same umbrella agency* | *Name of the umbrella agency* | *More than one mental health agency* | *Reporting levels between the Medicaid director and the Governor*[1] | *Interagency agreement or memorandum of understanding between the Medicaid and mental health agencies* |
|---|---|---|---|---|---|
| Tennessee | No | | No | One | Yes |
| Texas | No | | No | Two | NR |
| Utah | No | | No | One | Yes |
| Vermont | Yes | Agency of Human Services | No | Two | Yes |
| Virginia | Yes | Secretary of Health and Human Services | No | One | Yes |
| Washington | Yes | Department of Social and Health Services | No | One | — |
| West Virginia | Yes | Department of Health and Human Resources | No | Two | Yes |
| Wisconsin | Yes | WI Department of Health and Family Services | No | One | No |
| Wyoming | Yes | Department of Health | No | One | Yes |

NR = No response

[1] The number of formal organizational layers that exist between the Medicaid director and the Governor, not counting either the director or the Governor. (This would be "None" if the Medicaid director reports directly to the Governor.)

[2] Neither adult nor child mental health agencies are in same umbrella organization as Medicaid.

[3] Both adult and child mental health agencies are in the same umbrella organization as Medicaid.

[4] Medicaid and adult mental health agencies are in the same umbrella organization; the child mental health agency is separate.

[5] Interagency agreement between Medicaid agency and both child and adult mental health agencies.

[6] No response to existence of interagency agreement between Medicaid and adult mental health agency. An interagency agreement does exist between Medicaid and the child mental health agency.

[7] No response to the existence of an interagency agreement between Medicaid and the child mental health agency.

Two-thirds of the States reported that their Medicaid and mental health agencies have a formal interagency agreement or memorandum of understanding. States reported that these agreements were often used to define who is responsible for various services when clients are served by more than one agency. Not surprisingly, interagency agreements are much more common in States where the Medicaid agency and mental health agency are not under the same umbrella agency. Fewer than half the States where both agencies are within the same umbrella organization reported a formal interagency agreement between the two, while 91 percent of States where the agencies are separate have a formal interagency agreement.

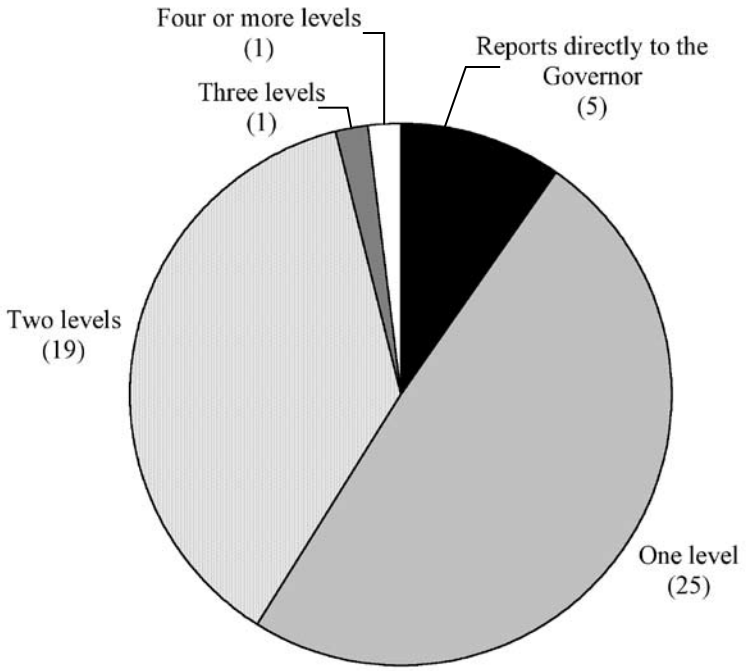
The survey did not ask explicitly about the history and impact of reorganizations. However, a number of respondents raised this issue during the course of the interview, especially if there had been recent reorganizations in the State or one was being planned or was under way. The text box called "Impact of Reorganizations" highlights some of the issues that emerged from these discussions of reorganizations.

## B. Funding, Services, and Providers

### *1. Funding Arrangements*

The rising importance of Medicaid funding in what used to be largely State-funded mental health systems is reflected in many States' funding arrangements for Medicaid mental health services. Federal Medicaid regulations prohibit Medicaid funding of mental health

**Figure 1: Reporting Levels Between the Medicaid Director and the Governor**



services for adults ages 22 to 64 in institutions for mental diseases (the IMD exclusion), so the shift toward community care has increased the opportunity for States to use Medicaid funding to provide mental health services (White & Draper, 2004). Since the States and the Federal Government jointly finance Medicaid, States that use Medicaid funding to deliver mental health services need to provide only the "State match," which currently ranges from 24 to 50 percent of the total cost of providing services, with the Federal Government providing the remainder. States have flexibility in choosing the source of State match funds for Medicaid-financed services. Usually, the State match for Medicaid services comes from the State general fund as part of the Medicaid agency budget. However, State match funds for mental health services may also be provided from the budget of other State agencies (usually the mental health agency) or from sources other than the State general fund.

In almost two-thirds of the States (32), the State match for Medicaid mental health services comes at least partially from the State mental health agency. This arrangement is more common in States with separate Medicaid and mental health agencies: 74 percent of States with separate agencies reported Medicaid match money was provided by the mental health agency, compared to 54 percent of States with an umbrella agency.

Slightly more than half of the States (26) reported that Medicaid State match funds come at least partially from sources other than the State general fund (Table 2). A major source of separate funding is counties, which provide Medicaid match funds for mental health services in 22 States. Other streams of Medicaid mental health dollars come from property taxes or other local revenue used to fund community mental health centers (CMHCs), or through schools or municipalities that provide funding for Medicaid mental health services to children. County funding occurs at about the same rate in States where Medicaid and mental health are under an umbrella agency as in States where the agencies are separate.

Some States track Medicaid spending on mental health services, while other States do not treat mental health as a separate category of services for Medicaid budgeting purposes. In slightly fewer than half of the States (23), the Medicaid agency maintains a separate line item in its budget for mental health services. This is more likely to occur in States where Medicaid and mental health are under the same umbrella agency. Half of all States with an umbrella agency have a separate line item for Medicaid mental health services, compared to only 39 percent of States with separate agencies.

### *2. Covered Services*

States reported electing to classify a wide range of services as Medicaid mental health services for State budgeting or rate-setting purposes. Every State reported that outpatient services provided by psychiatric or designated mental health providers were defined as Medicaid mental health services. Outpatient services provided at a community mental health center, mental health services provided under the rehabilitation option, and inpatient mental health services in a psychiatric hospital were classified by more than 45 States as Medicaid mental health services. Inpatient mental health services at a general hospital are classified as Medicaid mental health services in 43 States, and outpatient mental health services provided by a general or family physician are classified as Medicaid mental health services in 31 States.

## Impact of Reorganizations

In the interviews, a number of respondents reported State government reorganizations, with those from 10 States noting that significant reorganizations had occurred in the last 3 years or currently were being implemented. These reorganizations were generally the result of a gubernatorial initiative, and, with a small number of exceptions (most prominently New Mexico), were not aimed primarily at modifying relationships between Medicaid and mental health agencies. Nonetheless, most of the reported reorganizations affected those relationships. In some cases, respondents said the reorganizations facilitated a better relationship between the Medicaid and mental health agencies by aligning their projects and agendas and helping them to focus on common problems. In other cases, however, the reorganizations were perceived to disrupt established relationships by imposing new structures and reporting relationships and putting new people in positions of responsibility. Generally, if the reorganizations were driven by an attempt to align funding and policy and decrease silo behavior, respondents said State agencies had easier transitions and better ultimate outcomes.

### *Efforts to Align Funding and Policy*

In a few States, the reorganizations were driven by efforts to "put the budget where the policy was" by giving the mental health agency more authority over Medicaid funds. In one State, the respondent noted that financial issues drove the State reorganization and that the new system alleviated much of the friction that once existed between the mental health and Medicaid agencies. The new system put both within the same agency, but in different departments. Each department head now reports directly to the Governor, but there also is a policy cabinet that oversees the work of the departments.

Other States took a more comprehensive approach; in one State, the entire human services agency structure underwent extensive change in both organizational structure and leadership. In this State, the Medicaid and mental health agencies had been relatively autonomous, although the Medicaid agency clearly was the dominant force. Under the new structure, authority over Medicaid is more widely diffused among other human services agencies, and both Medicaid and mental health agencies are now lower in the overall organizational structure, below an executive secretary of health and human services.

### *Examples of Difficulties*

While reorganizations can improve relationships between the two agencies, they also can create tension and make collaboration more difficult. Some respondents reported that putting Medicaid and mental health agencies into two separate departments has led to increased polarization. However, the majority of States that have experienced negative consequences from reorganizations were those in which the two organizations were artificially merged as part of reorganizations that were not focused mainly on the relationships between Medicaid and mental health agencies. One respondent described it as "new, chaotic, and full of bumps" as the mental health authorities were moved into a newly formed department that also contains the Medicaid agency.

## Table 2: Sources of Medicaid Funding for Mental Health Services

| State | State General Fund | | Some State match for mental health services from different source than other State match funds | Other Funds[1] | | Other Match Funds Description |
|---|---|---|---|---|---|---|
| | Separate line item in Medicaid budget for mental health services | Mental health services funded by mental health authority | | Mental health services funded by county governments | Separate, dedicated funding stream for mental health | |
| **Total** | **23** | **32** | **26** | **22** | **9** | |
| Alabama | Yes | Yes | No | No | No | — |
| Alaska | Yes | Yes | Yes | — | Yes | Mental Health Trust Authority contributions and alcohol tax dollars. |
| Arizona | No | No | Yes | Yes | Yes | The State match is paid with a combination of general fund monies, a fixed contribution from each county, and tobacco-related dollars. |
| Arkansas | NR | No | No | No | No | — |
| California | Yes | No | Yes | Yes | Yes | County Realignment Funds, County General Funds, and Proposition 63. |
| Colorado | Yes | No | Yes | No | Yes | Tobacco Litigation Settlement Cash Fund funds mental health care for participants in the Breast and Cervical Cancer Program. |
| Connecticut | Yes | Yes[2] | No | No | No | — |
| Delaware | No | No | No | No | No | — |
| District of Columbia | No | Yes | No | — | No | — |
| Florida | Yes | Yes[3] | Yes | No | Yes | Certified local match. |
| Georgia | No | Yes | No | No | Yes | — |
| Hawaii | No | Yes | Yes | No | No | The Department of Health puts up the state match for services paid for by Adult Mental Health Division and Child & Adolescent Mental Health Division. |
| Idaho | No | No | Yes | No | No | Public schools put up a match for all school-based Medicaid services. |
| Illinois | No | Yes | No | Yes | No | — |
| Indiana | Yes | Yes | Yes | Yes | No | CMHCs use property tax money for the match for some discrete things, such as the Medicaid Rehab Option and SED. |
| Iowa | No | No | Yes | Yes | No | Property tax dollars from the counties . |

See notes at end of table.

*Continued*

Table 2: Sources of Medicaid Funding for Mental Health Services, *continued*

| State | State General Fund | | Some State match for mental health services from different source than other State match funds | Other Funds[1] | | Other Match Funds Description |
|---|---|---|---|---|---|---|
| | Separate line item in Medicaid budget for mental health services | Mental health services funded by mental health authority | | Mental health services funded by county governments | Separate, dedicated funding stream for mental health | |
| **Total** | **23** | **32** | **26** | **22** | **9** | |
| Kansas | Yes | Yes | Yes | Yes | No | CMHCs receive a certified match from the counties and from some cities. |
| Kentucky | No | No | No | No | No | — |
| Louisiana | No | No | No | No | No | — |
| Maine | Other[4] | Yes | No | No | No | — |
| Maryland | Yes | Yes | No | No | No | — |
| Massachusetts | No | Yes[3] | Yes | No | No | Municipal Medicaid for children in special education. Within an array of services, if mental health services are provided then the match is billed to municipalities. |
| Michigan | Yes | Yes | Yes | Yes | Yes | About $26 million comes from a local contribution to the sole-source local managed care organizations. |
| Minnesota | No | Yes | Yes | Yes | No | Counties. |
| Mississippi | No | Yes | Yes | Yes | No | Special funds and tobacco settlement funds. Mental health in particular receives funding through counties. DMH secures State general funds for CMHCs, but when the funding is short, counties cover the match. |
| Missouri | No | Yes | Yes | Yes | No | For certain facility-based services (i.e., inpatient psych for under 21), the State draws down the Federal Medicaid match by using State employee salaries as "certified public expenditures." |
| Montana | Yes | Yes | Yes | Yes | Yes | Counties give the money to the mental health authority to use for the State match. |
| Nebraska | Yes | No | No | No | No | — |
| Nevada | No | Yes | Yes | Yes | No | County school districts have their own revenue streams and their funds are used for public matters. |
| New Hampshire | Yes | Yes | No | No | No | — |

See notes at end of table.

*Continued*

Table 2: Sources of Medicaid Funding for Mental Health Services, *continued*

| State | State General Fund | | Some State match for mental health services from different source than other State match funds | Other Funds[1] | | Other Match Funds Description |
|---|---|---|---|---|---|---|
| | Separate line item in Medicaid budget for mental health services | Mental health services funded by mental health authority | | Mental health services funded by county governments | Separate, dedicated funding stream for mental health | |
| New Jersey | Yes | Yes[6] | No | No | No | — |
| New Mexico | Yes | No | Yes | Yes | No | City and county funds. |
| New York | No | Yes | Yes | Yes | No | The local governments provide 25% for acute care services and 10% for long-term care services. Some services have no local share. |
| North Carolina | Yes | No | Yes | Yes | No | County funds. |
| North Dakota | No | No | No | No | No | — |
| Ohio | No | Yes | Yes | Yes | No | By the local boards, which raise money independently through mill levies. |
| Oklahoma | No | Yes | No | No | No | — |
| Oregon | NR | Yes[3] | No | Yes | No | — |
| Pennsylvania | Yes | No | No | No | No | — |
| Rhode Island | No | Yes | No | No | No | — |
| South Carolina | No | Yes | Yes[5] | Yes[5] | No | State Mental Health Authority may receive funding from county governments that may be used as matching funds. |
| South Dakota | No | No | No | No | No | — |
| Tennessee | Yes | No | No | No | No | — |
| Texas | NR | Yes | No | No | No | — |
| Utah | Yes | Yes | Yes | Yes | Yes | Outpatient services are funded through a combination of State pass-through, local county, and Federal matching funds. |
| Vermont | No | Yes | No | No | No | — |
| Virginia | Yes | Yes | Yes | Yes | No | Local match for children's services: three levels of residential treatment, and one type of targeted case management. |
| Washington | Yes | Yes | Yes | Yes | No | Local and county-level funds. |

See notes at end of table.

*Continued*

Table 2: Sources of Medicaid Funding for Mental Health Services, *continued*

| | State General Fund | | Some State match for mental health services from different source than other State match funds | Other Funds[1] | | Other Match Funds Description |
|---|---|---|---|---|---|---|
| **State** | **Separate line item in Medicaid budget for mental health services** | **Mental health services funded by mental health authority** | | **Mental health services funded by county governments** | **Separate, dedicated funding stream for mental health** | |
| West Virginia | No | No | No | No | No | — |
| Wisconsin | Yes | No | Yes | Yes | No | 100% county match for community support programs, crisis services, and targeted case management . |
| Wyoming | Yes | No | No | No | No | — |

NR = No response

[1] May flow into the State general fund in some states.

[2] For Family Medicaid only.

[3] The State mental health authority provides match for some services, not all.

[4] The legislature appropriates some money to the State mental health authority, which is matched and paid out through Medicaid. Medicaid also has a separate fund/account that also gets money from the mental health office.

[5] In State mental health authority budget, not Medicaid budget.

[6] State institution services only.

Thirty-nine States classified psychotropic drugs as Medicaid mental health services, although these drugs generally were included with other prescription drugs for Medicaid rate-setting and budget purposes (see Appendix A, Table A.2, for State-specific information). Half of the States reported that services other than those listed above are also defined as Medicaid mental health services. The most common of these other services were targeted case management (in 10 States) and mental health services to children under EPSDT[13] (5 States). One State reported that all mental health services for children are classified as EPSDT services.

### *3. Rate-Setting Authority*

Just under half of the States report delegating authority to set rates for at least some Medicaid mental health services to the mental health agency (Table 3). The most common type of Medicaid service for which mental health agencies have rate-setting authority is residential treatment (17 States), followed by services provided by psychiatric social workers, targeted case management, and psychosocial rehabilitation (in 16 States). Mental health agencies are least likely to have authority over the rates for inpatient mental health services in general or psychiatric hospitals. (See Appendix A, Table A.1, for State-specific information.)

In the 25 States where the mental health agency has the authority to set rates, the number of services for which the agency can set rates varies widely. In five States, the mental health agency can set only one rate, either for services provided at a mental health clinic or for home- and community-based services. In 11 States, the agency has the authority to set rates for between two and nine Medicaid mental health services. Nine more States allow the mental health agency to set rates for more than 10 services, including one State that allows it to set rates for all Medicaid mental health services. In States where the mental health agency has rate-setting authority, it sets an average of seven rates.

States in which the mental health agency has rate-setting authority are more likely to have counties provide part of the State match for Medicaid mental health services (52 percent), compared to States where the mental health agency sets no rates (35 percent). Mental health agencies that have the authority to set rates also are much more likely to provide some Medicaid match funding themselves. Medicaid mental health services are funded by mental health agencies in 76 percent of the States where the agency has rate-setting authority, as opposed to only half the States where the mental health agency has no rate-setting authority.

[13] The Early Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for beneficiaries under age 21.

Table 3: Medicaid Services for Which Mental Health Agencies Set Rates

| *Mental Health Agencies with Rate-setting Authority* | *25* |
|---|---|
| **Services…** | |
| Residential treatment | 17 |
| Psychiatric social workers | 16 |
| Targeted case management | 16 |
| Psychosocial rehabilitation | 16 |
| Partial day treatment | 15 |
| Outpatient hospital services | 13 |
| Mental health clinic | 10 |
| Services of other licensed professionals | 10 |
| Physician services | 10 |
| Clinical psychologists | 9 |
| Family support services | 9 |
| Individual, group, or family therapy | 8 |
| Respite care | 8 |
| School-based services | 7 |
| Home and community-based services | 7 |
| Inpatient mental health—general hospital | 6 |
| Inpatient mental health—psychiatric hospital | 4 |

### *4. Medicaid Mental Health Providers*

In addition to deciding what services to cover and setting rates for those services, Medicaid agencies must define what types of providers are qualified to provide services to Medicaid beneficiaries and enroll willing providers. States are generally required to allow any qualified provider who is willing to provide services at the reimbursement level set by the Medicaid program to enroll as a provider. "Provider" is broader than just individual practitioners; States can also enroll health care plans as providers in managed care States, for example, and clinics and other health centers can enroll as providers in many States.

While nine States define Medicaid mental health providers very broadly, as any provider[14] that provides a mental health service (Table 4), the majority (26) restrict the definition to providers with a mental health or psychiatric designation. A few States (13) have some other definition for a Medicaid mental health provider.[15]

[14] In one State, a provider is defined as any physician who provides a mental health service.

[15] Five of the States with an "other" definition define Medicaid mental health providers as physicians with a mental health or psychiatric designation, plus a few other mental health professionals such as mental health behavioral aides and licensed counselors. One State defines a Medicaid mental health provider as any provider with a mental health or psychiatric designation but uses a broader definition in rural areas.

## Table 4: Medicaid Mental Health Providers

| *State* | *Provider definition* | *Must be certified or enrolled through the mental health agency* | *Medicaid mental health providers are capped in terms of yearly reimbursement* | *Medicaid mental health providers paid differently than other Medicaid providers* |
|---|---|---|---|---|
| **Total** | | **22** | **7** | **20** |
| Alabama | Providers with a psychiatric or mental health designation | Yes | No | Yes |
| Alaska | Other definition of Medicaid mental health provider | Yes | No | No |
| Arizona | Other definition of Medicaid mental health provider | No | Yes | Yes |
| Arkansas | Providers with a psychiatric or mental health designation | No | No | No |
| California | Providers with a psychiatric or mental health designation | Yes | No | Yes |
| Colorado | Providers with a psychiatric or mental health designation | No | No | Yes |
| Connecticut | Providers with a psychiatric or mental health designation | No | No | No |
| Delaware | Providers with a psychiatric or mental health designation | No | No | Yes |
| District of Columbia | Providers with a psychiatric or mental health designation | Yes | Yes | Yes |
| Florida | Other definition of Medicaid mental health provider | Yes | No | No |
| Georgia | Providers with a psychiatric or mental health designation | Yes | No | Yes |
| Hawaii | Providers with a psychiatric or mental health designation | No | No | No |
| Idaho | Other definition of Medicaid mental health provider | No | No | No |
| Illinois | Any provider providing a mental health service | NR | Yes | Yes |
| Indiana | Providers with a psychiatric or mental health designation | No | No | No |
| Iowa | Any provider providing a mental health service | No | No | No |
| Kansas | Other definition of Medicaid mental health provider | Yes[1] | No | No |
| Kentucky | Other definition of Medicaid mental health provider | Yes | No | No |
| Louisiana | Providers with a psychiatric or mental health designation | Yes | No | No |
| Maine | Any provider providing a mental health service | Yes | No | No |
| Maryland | Providers with a psychiatric or mental health designation | No | No | Yes |

See notes at end of table.

*Continued*

Table 4: Medicaid Mental Health Providers, *continued*

| *State* | *Provider definition* | *Must be certified or enrolled through the mental health agency* | *Medicaid mental health providers are capped in terms of yearly reimbursement* | *Medicaid mental health providers paid differently than other Medicaid providers* |
|---|---|---|---|---|
| **Total** | | **22** | **7** | **20** |
| Massachusetts | Providers with a psychiatric or mental health designation | No | No | No |
| Michigan | Other definition of Medicaid mental health provider | Yes | Yes | Yes |
| Minnesota | Other definition of Medicaid mental health provider | Yes | No | Yes[2] |
| Mississippi | Providers with a psychiatric or mental health designation | No | No | No |
| Missouri | Other definition of Medicaid mental health provider | Yes[3] | No | No |
| Montana | Providers with a psychiatric or mental health designation | No | No | No |
| Nebraska | Other definition of Medicaid mental health provider | No | No | No |
| Nevada | Any provider providing a mental health service | No | No | No |
| New Hampshire | Providers with a psychiatric or mental health designation | No | No | No |
| New Jersey | Providers with a psychiatric or mental health designation | Yes | No | No |
| New Mexico | Providers with a psychiatric or mental health designation | No | No | Yes |
| New York | Providers with a psychiatric or mental health designation | No | No | No |
| North Carolina | Any provider providing a mental health service | Yes | No | Yes |
| North Dakota | Other definition of Medicaid mental health provider | No | No | No |
| Ohio | Any provider providing a mental health service | Yes | No | Yes |
| Oklahoma | Providers with a psychiatric or mental health designation | No | No | No |
| Oregon | Other definition of Medicaid mental health provider | Yes | Yes | Yes |
| Pennsylvania | Providers with a psychiatric or mental health designation | Yes | No | Yes |
| Rhode Island | Any provider providing a mental health service[4] | Yes | No | No |
| South Carolina | Providers with a psychiatric or mental health designation | No | No | No |
| South Dakota | Providers with a psychiatric or mental health designation | No | Yes | No |

See notes at end of table.

*Continued*

Table 4: Medicaid Mental Health Providers, *continued*

| *State* | *Provider definition* | *Must be certified or enrolled through the mental health agency* | *Medicaid mental health providers are capped in terms of yearly reimbursement* | *Medicaid mental health providers paid differently than other Medicaid providers* |
|---|---|---|---|---|
| **Total** | | **22** | **7** | **20** |
| Tennessee | Any provider providing a mental health service | Yes | No | Yes |
| Texas | Any provider providing a mental health service | No | No | Yes |
| Utah | Providers with a psychiatric or mental health designation | No | No | Yes[2] |
| Vermont | Other definition of Medicaid mental health provider | No | No | No |
| Virginia | Providers with a psychiatric or mental health designation | No | No | No |
| Washington | Providers with a psychiatric or mental health designation | Yes | Yes | Yes |
| West Virginia | Providers with a psychiatric or mental health designation | No | No | No |
| Wisconsin | Providers with a psychiatric or mental health designation | No | No | No |
| Wyoming | Providers with a psychiatric or mental health designation | Yes | No | No |

NR = No response

[1] For some providers.

[2] Providers paid differently for some Medicaid populations.

[3] For the Community Psychiatric Rehabilitation (CPR) and Comprehensive Substance Treatment & Rehabilitation (CSTAR) programs only.

[4] Only physicians may be providers.

As noted in the beginning of the chapter, States also have flexibility to delegate the responsibility of certifying and enrolling providers to agencies other than the Medicaid agency. Twenty-two States require some or all Medicaid mental health providers to be enrolled or certified through the mental health agency. States with a more restrictive definition of mental health providers (only those with a psychiatric or mental health designation) are less likely to require providers to be enrolled or certified through the mental health agency. Only 31 percent of States with the restrictive definition require certification or enrollment through the mental health agency, compared to 56 percent with the broader definition and 62 percent of the States with an "other" definition.

States where the mental health agency has the authority to set at least some rates were more likely to require providers to be certified or enroll through the mental health agency. More than half of the States (52 percent) reporting that the mental health agency has rate-setting authority required providers to enroll through the mental health agency, while only 35 percent of the States where the mental health agency had no rate-setting authority required this.

Only seven States reported capping the amount of reimbursement that a mental health provider can receive per year from

Medicaid. States using broader or more restrictive definitions were equally likely to use a cap.

In 20 States, mental health providers are paid differently than other providers. In nine States, mental health providers submit their claim to and are paid by the mental health agency, rather than the Medicaid agency.[16] In Ohio, for example, county-level mental health authorities pay the claim for community mental health services and file for reimbursement from Medicaid through the mental health agency. In 10 States, some or all mental health providers are paid through a behavioral health organization (BHO) or an administrative services organization (ASO) rather than directly through the Medicaid claims processing system. These types of organizations are discussed further in the managed care section below.

States using a broader provider definition are more likely to pay Medicaid mental health providers differently from other Medicaid providers than are States using a more restrictive definition: 56 percent using a broader definition as opposed to 38 percent using a more restrictive definition and 31 percent using an "other" definition.

### *5. Managed Care*

As of June 30, 2005, nearly 63 percent of Medicaid beneficiaries were enrolled in some form of managed care, with almost half enrolled in prepaid capitated plans in which the health plan was at risk for some or all Medicaid services (Centers for Medicare & Medicaid Services [CMS], 2005).

The survey asked about two types of organizations that might provide behavioral health care differently than other Medicaid services: BHOs, in which the State makes capitated payments to organizations that are at risk for the services they provide, and ASOs, which administer services on a fee-for-service basis, but are not at risk if needed services exceed State payments.[17] Twenty-six States reported that the State contracts with a BHO or ASO for mental health service delivery. (See Appendix A, Table A.3, for State-specific information.)

The survey also asked whether any mental health services or populations were carved out of Medicaid managed care contracts and, if so, which services or populations were carved out. The survey did not ask systematically about the nature of these Medicaid managed care contracts or how the "carved out" services or populations were dealt with. In some cases, the respondents were referring to general Medicaid managed care contracts, and the "carved out" services or populations were dealt with in the Medicaid fee-for-service program or in BHOs or ASOs. In others, the respondents were referring to BHO and ASO contracts, and the "carved out" services are behavioral health services that remain in the Medicaid fee-for-service program.

A number of States reported that mental health services were carved out of Medicaid fee-for-service and managed care, and that the mental health agency itself (or county/local mental health agencies) acted as a plan

[16] In most of these States, all mental health claims are paid through the mental health agency. However, in two States, only certain mental health services are paid through the mental health agency (for example, rehabilitation services or services for children in State custody), while all other mental health claims are paid the same as nonmental health claims.

[17] Some ASO administrative payments may be at risk if the ASOs do not meet administrative or other performance standards established in their contracts with the State.

in providing Medicaid mental health services, with funding from Medicaid. In other States, the mental health agency contracted with independent managed care organizations rather than acting as a plan and delivering services on its own, again using funding from Medicaid.

Twenty-three of the 26 States using a BHO or ASO reported that they do not deliver services to all Medicaid mental health beneficiaries in the same way, excluding at least some Medicaid mental health services or populations from the BHO or ASO or from broader Medicaid managed care programs. These excluded services or populations are covered in the regular Medicaid fee-for-service program.

Of the 25 States that reported not using a BHO or ASO to deliver mental health services, 11 carve out or exclude at least some mental health services or populations from broader Medicaid managed care programs. Only 10 States do not use either a BHO or an ASO for mental health services, nor do they carve out any mental health services or populations from general Medicaid managed care programs, thus covering these services and populations in the same way as all other Medicaid services and populations.

## C. Data Collection and Reporting

As noted earlier, every State Medicaid program, as a condition of receiving Federal matching funds, must collect enrollment and claims data in a Medicaid Management Information System (MMIS) in standardized formats specified by CMS, and it must report specified data to CMS electronically through the Medicaid Statistical Information System (MSIS).[18] Individual States may also require the Medicaid program to report certain financial or programmatic data to the State legislature or the general public.

### *1. Reports on Medicaid Mental Health Services*

Eighty percent of the States (40) reported that their Medicaid agencies produce formal reports containing discrete data on mental health utilization or expenditures (Table 5). Of the remaining States, eight reported that the mental health agency produces these reports, two reported that neither the Medicaid agency nor any other State agency produces reports that break out the utilization or cost of mental health services within the State Medicaid program, and one did not report the information.

These reports most commonly contain the number of beneficiaries utilizing mental health services (in 32 States), followed by utilization (30 States), utilization by service and cost by service (29 States), and cost per beneficiary (26 States). In 22 States, the Medicaid agency produces these reports monthly; in 6 States, annually; in 5 States, quarterly; and in 1 State, semiannually. There are four States in which the Medicaid agency produces reports on mental health services only on an "as needed" basis.

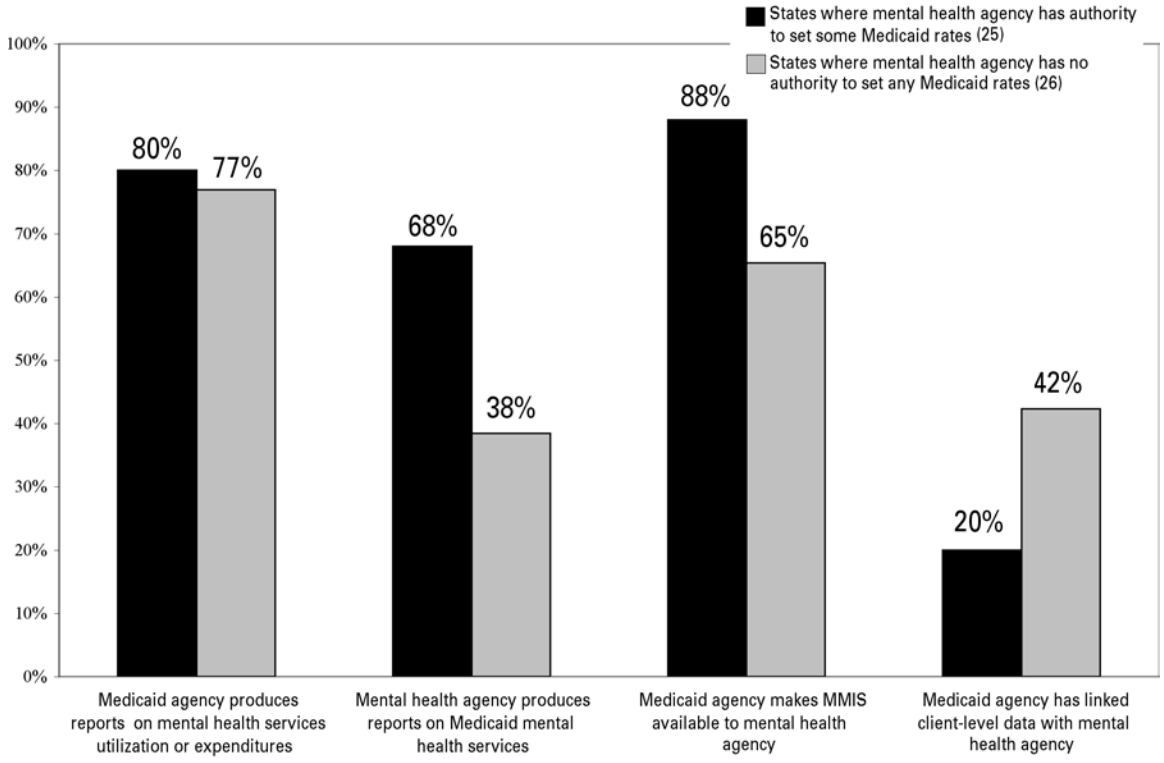
In eight States, all reports produced by Medicaid about mental health services are publicly available, while in seven States, reports are only available internally. Most (22 States) have a mix of publicly available and internal-only reports. Of the 29 States in which some or all of the mental health services reports are available only internally, there are 26 in which the Medicaid agency shares the report with other State agencies.

[18] Social Security Act, Section 1903(r)(1).

### *2. Reports on Medicaid Mental Health Services Produced by Mental Health and Other Agencies*

In slightly more than half of the States (27), the mental health agency produces a report on Medicaid mental health spending or utilization. States where the mental health agency has the authority to set rates also are more likely to have the mental health agency produce reports on Medicaid mental health services (Figure 2). More than two-thirds of mental health agencies that set rates also produce reports, while only 38 percent of those agencies that do not set rates do so. The mental health agency also is more likely to produce these reports in States where Medicaid and mental health are in separate agencies.

Figure 2: Rate-setting Authority, Mental Health Services Reports, and Data Sharing



## Table 5: Formal Reports on Medicaid Mental Health Services

| State | The Medicaid agency produces reports in which there is discrete data included on mental health utilization or expenditures | Report Contents | | | | | | Frequency of report | Type of report | Internal reports are shared with other agencies | Medicaid mental health reports are generated by other State agencies |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Number of beneficiaries | Utilization | Utilization by service | Cost per beneficiary | Cost by service | Other | | | | |
| **Total** | **40** | **32** | **30** | **29** | **26** | **29** | **14** | | | **25** | **32** |
| Alabama | Yes | Yes | Yes | Yes | Yes | No | No | As needed | Internal only | Yes | Yes |
| Alaska | Yes | Yes | Yes | Yes | No | No | No | Monthly | Mix of public and internal | Yes | No |
| Arizona | Yes | Yes | Yes | Yes | Yes | Yes | No | Monthly | Mix of public and internal | Yes | Yes |
| Arkansas | NR | NR | NR | NR | NR | NR | NR | NR | NR | NR | NR |
| California | No | — | — | — | — | — | — | — | — | — | Yes |
| Colorado | Yes | Yes | Yes | Yes | Yes | No | No | Annually | Mix of public and internal | Yes | No |
| Connecticut | Yes | No | No | No | No | Yes | Yes | Monthly | Mix of public and internal | Yes | NR |
| Delaware | Yes | Yes | Yes | Yes | Yes | Yes | No | Quarterly | Internal only | Yes | Yes |
| District of Columbia | No | — | — | — | — | — | — | — | — | — | No |
| Florida | Yes | Yes | Yes | Yes | Yes | Yes | No | As needed | Mix of public and internal | Yes | Yes |
| Georgia | Yes | Yes | No | Yes | No | Yes | Yes | Monthly | Mix of public and internal | Yes | Yes |
| Hawaii | Yes | Yes | Yes | Yes | No | No | Yes | Monthly | Mix of public and internal | No | No |
| Idaho | Yes | NR | NR | NR | NR | NR | NR | NR | NR | NR | NR |
| Illinois | No | — | — | — | — | — | — | — | — | — | Yes |
| Indiana | Yes | Yes | Yes | Yes | Yes | Yes | No | Monthly | Mix of public and internal | Yes | No |
| Iowa | Yes | No | Yes | No | Yes | Yes | No | Quarterly | Publicly available only | — | No |
| Kansas | Yes | Yes | No | No | Yes | No | No | Monthly | — | — | Yes |
| Kentucky | Yes | Yes | Yes | Yes | Yes | Yes | No | Monthly | Internal only | No | NR |
| Louisiana | Yes | Yes | No | No | Yes | No | Yes | Monthly | Publicly available only | — | Yes |
| Maine | No | — | — | — | — | — | — | — | — | — | Yes |

See notes at end of table.

*Continued*

Table 5: Formal Reports on Medicaid Mental Health Services, *continued*

| State | The Medicaid agency produces reports in which there is discrete data included on mental health utilization or expenditures | Report Contents | | | | | | Frequency of report | Type of report | Internal reports are shared with other agencies | Medicaid mental health reports are generated by other State agencies |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Number of beneficiaries | Utilization | Utilization by service | Cost per beneficiary | Cost by service | Other | | | | |
| **Total** | **40** | **32** | **30** | **29** | **26** | **29** | **14** | | | **25** | **32** |
| Maryland | No | — | — | — | — | — | — | — | — | | Yes |
| Massachusetts | Yes | Yes | Yes | Yes | Yes | Yes | No | Quarterly | Publicly available only | — | Yes |
| Michigan | No | — | — | — | — | — | — | — | — | | Yes |
| Minnesota | Yes | No | No | No | No | Yes | No | Annually | Mix of public and internal | NR | NR |
| Mississippi | Yes | Yes | Yes | Yes | Yes | Yes | No | Semi-Annual | Internal only | Yes | Yes |
| Missouri | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Monthly | Publicly available only | — | Yes |
| Montana | Yes | Yes | Yes | Yes | No | Yes | No | Monthly | Mix of public and internal | Yes | Yes |
| Nebraska | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Monthly | Mix of public and internal | Yes | No |
| Nevada | Yes | Yes | Yes | Yes | No | Yes | Yes | Monthly | Mix of public and internal | Yes | Yes |
| New Hampshire | Yes | Yes | Yes | Yes | Yes | Yes | No | Monthly | Publicly available only | — | No |
| New Jersey | No | — | — | — | — | — | — | — | — | — | No |
| New Mexico | Yes | Yes | Yes | Yes | Yes | Yes | No | Monthly | Mix of public and internal | Yes | Yes |
| New York | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Annual | Internal only | Yes | Yes |
| North Carolina | Yes | Yes | Yes | No | No | No | Yes | Monthly | Publicly available only | — | Yes |
| North Dakota | Yes | No | Yes | No | Yes | Yes | Yes | Monthly | Mix of public and internal | Yes | No |
| Ohio | Yes | No | No | Yes | No | Yes | Yes | As needed | Mix of public and internal | Yes | Yes |
| Oklahoma | Yes | Yes | Yes | Yes | Yes | Yes | No | Quarterly | Mix of public and internal | Yes | Yes |
| Oregon | Yes | Yes | No | No | Yes | No | No | Monthly | Mix of public and internal | NR | NR |
| Pennsylvania | No | — | — | — | — | — | — | — | — | — | Yes |

See notes at end of table.

*Continued*

Table 5: Formal Reports on Medicaid Mental Health Services, *continued*

| State | The Medicaid agency produces reports in which there is discrete data included on mental health utilization or expenditures | Report Contents | | | | | | Frequency of report | Type of report | Internal reports are shared with other agencies | Medicaid mental health reports are generated by other State agencies |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Number of beneficiaries | Utilization | Utilization by service | Cost per beneficiary | Cost by service | Other | | | | |
| **Total** | **40** | **32** | **30** | **29** | **26** | **29** | **14** | | | **25** | **32** |
| Rhode Island | Yes | Yes | Yes | Yes | Yes | No | No | Annually | Publicly available only | — | Yes |
| South Carolina | Yes | Yes | Yes | Yes | Yes | Yes | No | Monthly | Mix of public and internal | Yes | Yes |
| South Dakota | Yes | No | No | No | No | Yes | Yes | Annually | Internal only | No | Yes |
| Tennessee | No[1] | — | — | — | — | — | — | — | — | — | Yes |
| Texas | No | — | — | — | — | — | — | — | — | — | Yes |
| Utah | Yes | Yes | Yes | Yes | Yes | Yes | No | As needed | Internal only | Yes | No |
| Vermont | Yes | Yes | Yes | Yes | No | Yes | No | Quarterly | Mix of public and internal | Yes | Yes |
| Virginia | Yes | Yes | Yes | Yes | No | Yes | No | Annually | Publicly available only | — | Yes |
| Washington | Yes | No | No | No | No | No | Yes | Monthly | Mix of public and internal | Yes | Yes |
| West Virginia | Yes | Yes | Yes | Yes | Yes | Yes | No | Monthly | Mix of public and internal | Yes | NR |
| Wisconsin | Yes | Yes | Yes | Yes | Yes | Yes | No | Annually | Mix of public and internal | Yes | No |
| Wyoming | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Monthly | Mix of public and internal | Yes | Yes |

NR = No response

[1] TennCare incorporates reports from the mental health agency on these topics in the quarterly report that is submitted to CMS.

The other agency that most commonly produces reports on Medicaid mental health services utilization or expenditures is children and family services (five States). There are 32 States where an agency other than the Medicaid agency produces reports on Medicaid mental health services. In addition to the information on Medicaid mental health services, these reports may include breakdowns on case histories and outcomes, as well as service users.

### *3. Data Sharing*

More than three-quarters of the States make data from the MMIS available to the mental health agency for analysis. The organizational structure of the Medicaid and mental health agencies within the State government does not affect the likelihood of sharing MMIS data, but the ability of the mental health agency to set rates does (Figure 2): mental health agencies with the authority to set rates are much more likely to have access to the MMIS than mental health agencies with no such authority (88 vs. 65 percent).

In 40 States, the MMIS is used for the analysis of mental health service utilization, either by the Medicaid agency or another State agency. It is used somewhat less frequently to link to client-level data for administrative purposes (34 States), or to link to client-level data for policy analysis (32 States).

In a little less than half of the States, the Medicaid agency has integrated or linked its client data sets with those of other agencies (Table 6), most commonly the State mental health agency. The organizational structure has little effect on whether Medicaid links its client data sets with the mental health agency: slightly less than one-third of all States do so, regardless of whether the agencies are within the same umbrella organization. (See Appendix A, Table A.5, for State-specific information.)

**Table 6: Integrated Data Sets**

| ***Medicaid Agencies That Have Linked Client Data Sets*** | ***25*** |
|---|---|
| **Linked to client data sets at….** | |
| Mental health agency | 16 |
| Social services agency | 11 |
| Children and family services agency | 10 |
| Corrections agency | 7 |
| Health department | 7 |
| Substance abuse agency | 7 |
| Juvenile justice agency | 4 |
| Education department | 3 |
| Budget office staff | 2 |
| State legislative staff | 2 |
| Governor's office staff | 1 |
| Other | 1 |

### *4. Data Sharing and Rate-Setting Authority*

The MMIS is available more often to mental health agencies that have rate-setting authority than to those without that authority. However, States in which the mental health agency sets some Medicaid rates actually are less likely to link Medicaid and mental health data sets at the client level than those in which the mental health agency sets no rates (20 vs. 42 percent). This low percentage suggests that a basic level of access to Medicaid data on service utilization rates and payment to providers is needed for the mental health agency to participate in setting Medicaid rates but that more detailed linking at the client level may be less necessary. Client-level data linking is more likely to be needed for analysis of clinical issues and to determine whether particular types of clients are over- or underusing services, so mental health agencies that focus more on these issues than on issues of provider payment may be more inclined to seek the extra step of linking Medicaid and mental health data at the client level.

### *5. Uses of Data*

State reports of data use varied greatly. Several States echoed the sentiments of one, that they are "very data driven," while others noted that "data is always a struggle" or that they have "definitely got too much [data]" but not enough staff to utilize the data fully. Two States mentioned that they do not use data at all. The majority of States reported recent efforts to improve their data. More than two-thirds of the States (36) reported improving the availability or the quality of Medicaid mental health data during the past 3 years, although these improvements generally have been targeted at all Medicaid data rather than just on mental health. Many mentioned future plans, including building data warehouses, creating integrated databases, and purchasing a new MMIS.

The most common use of Medicaid mental health data is in reports. Almost 80 percent of State Medicaid agencies currently produce formal reports containing a considerable range of information, most commonly the various dimensions of cost and utilization. Most States said that they also use these data for operational purposes, such as budgeting and rate setting. Several States reported using data for analysis: to better analyze who was using which mental health services as a way to understand gaps in care and underserved populations. A few noted that they use data for policy setting as well. One State reported that its mental health authority uses Medicaid claims data to monitor the effects of policy changes by examining utilization of relevant services. Another noted that it is "trying to promote community health" by marrying outcomes data to utilization data to find best practices that will influence policy. Yet another State said that its Medicaid agency uses MMIS data to look at individuals with chronic illnesses and behavioral health issues and that it tries to unite existing policies to streamline processes.

## D. Summary

**Organizational Structure.** State Medicaid and mental health agencies are within the same umbrella agency in 28 States and are separate in 23 States. Seven States reported having more than one State-level mental health agency. In the vast majority of States, two or fewer reporting levels separate the Medicaid director from the Governor.

**Funding and Providers.** In 32 States, the State match for Medicaid mental health services comes at least partially from the mental health agency. In 22 States, some funding for Medicaid mental health services comes from counties or other local sources. In 23 States, the Medicaid agency has a separate line item in the budget for mental health services. In almost half of the States, the mental health agency has the authority to set some Medicaid mental health rates, most commonly for residential treatment, psychiatric social workers, targeted case management, and psychosocial rehabilitation.

**Managed Care.** Twenty-six States reported that at least some Medicaid mental health services or populations are covered through BHOs or ASOs. Of the 25 States that report not using a BHO or ASO, 11 carve out or exclude at least some mental health services or populations from broader Medicaid managed care programs. There are only 10 States that do not use any of these managed care arrangements.

**Data and Reporting.** Forty States reported that their Medicaid agencies produce formal reports containing discrete data on mental

health utilization or expenditures, including utilization and cost by service (29 States) and cost per beneficiary (26 States). In 27 States, the mental health agency produces reports on Medicaid mental health spending or utilization. At least some of these reports are publicly available in 30 of the States, while in 7 States all reports are internal only.

# III. Medicaid Agency Collaboration With Mental Health Agencies

States differ in the degree to which the State Medicaid agencies collaborate with mental health agencies. As noted in the previous chapter, States have the flexibility to allow agencies other than the single State Medicaid agency to administer aspects of the Medicaid program, as long as the Medicaid agency retains overall responsibility. To the extent that States have elected to have the mental health agency administer Medicaid services, certify and enroll providers, pay claims, and establish policy, collaboration between the two agencies is an important aspect of Medicaid administration of mental health services. The survey asked Medicaid agencies about the extent of formal collaboration between the two agencies, as well as joint participation in policy-making groups and other less formal indicators of collaboration. This section summarizes these responses, as well as responses to more open-ended questions about collaboration.

## A. Measures of Collaboration

The survey asked a number of questions that can be used to assess the type and degree of collaboration that exists between Medicaid and mental health agencies. The results are summarized below.

### *1. External Collaboration*

Slightly more than half of the States reported that the Medicaid and mental health agencies frequently collaborate on external meetings, public reports, or presentations to the legislature (Table 7). Nine States reported that the agencies collaborate somewhat regularly on these activities, and 15 States reported that the agencies collaborate occasionally. None of the States reported that the Medicaid and mental health agencies never collaborate.

### *2. Staff Meetings*

One-third of the States (17) hold weekly or biweekly meetings between the Medicaid and mental health agency staffs. Another 11 States reported monthly meetings; 6 States reported quarterly meetings; and one State reported biannual meetings. The staffs meet on an "as needed" basis in the remaining 13 States.

## Table 7: Collaboration

| State | How often do the Medicaid and mental health agencies collaborate? | How often are there regularly scheduled meetings between staff at the two agencies? | Directors of the two agencies have regularly scheduled meetings | Medicaid staff member who is the point person on mental health issues | Medicaid agency is represented on State mental health planning council | Medicaid agency participates in development of mental health plan | Mental Health Representation on MCAC | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | At least one slot reserved for mental health representative on MCAC[1] | Type of Representative | | | |
| | | | | | | | | Consumer | Provider | Mental health department | Other |
| **Total** | | | **34** | **37** | **42** | **36** | **32** | **12** | **22** | **12** | **6** |
| Alabama | Frequently | Quarterly | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Alaska | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Arizona | Somewhat Regularly | Quarterly | No | Yes | Yes | Yes | No | — | — | — | — |
| Arkansas | NR | Monthly | NR | Yes | Yes | NR | NR | NR | NR | NR | NR |
| California | Somewhat Regularly | Monthly | Yes | Yes | No | No | NR | NR | NR | NR | NR |
| Colorado | Occasionally | As needed | No | Yes | Yes | No | Yes | No | Yes | No | No |
| Connecticut | Frequently | As needed | Yes | Yes | Yes | NR | Other [2] | — | — | — | — |
| Delaware | Occasionally | Biannually | Yes | No | Yes | Yes | Yes | Yes | No | Yes | No |
| District of Columbia | Occasionally | Quarterly | Yes | Yes | No | No | Yes | No | No | Yes | No |
| Florida | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | NR | NR | NR | NR | NR |
| Georgia | Somewhat Regularly | As needed | No | Yes | No | Yes | Yes | No | Yes | Yes | No |
| Hawaii | Occasionally | Quarterly | Yes | No | Yes | No | No | — | — | — | — |
| Idaho | Frequently | Monthly | NR | Yes | Yes | Yes | Yes | NR | NR | NR | NR |
| Illinois | Frequently | Weekly or biweekly | No | No | NR | NR | No | — | — | — | — |
| Indiana | Occasionally | As needed | Yes | No | No | Yes | Yes | No | No | Yes | No |

See notes at end of table.

*Continued*

Table 7: Collaboration, *continued*

| State | How often do the Medicaid and mental health agencies collaborate? | How often are there regularly scheduled meetings between staff at the two agencies? | Directors of the two agencies have regularly scheduled meetings | Medicaid staff member who is the point person on mental health issues | Medicaid agency is represented on State mental health planning council | Medicaid agency participates in development of mental health plan | Mental Health Representation on MCAC | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | At least one slot reserved for mental health representative on MCAC[1] | Type of Representative | | | |
| | | | | | | | | Consumer | Provider | Mental health department | Other |
| **Total** | | | **34** | **37** | **42** | **36** | **32** | **12** | **22** | **12** | **6** |
| Iowa | Occasionally | Monthly | Yes | Yes | No | No | Yes | Yes | Yes | No | Yes |
| Kansas | Somewhat Regularly | Monthly | No | Yes | Yes | Yes | No | — | — | — | — |
| Kentucky | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | No | — | — | — | — |
| Louisiana | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | Yes | Yes | No | No | No |
| Maine | Frequently | Other | Yes | No | No | Yes | Yes | Yes | Yes | No | No |
| Maryland | Frequently | Weekly or biweekly | No | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Massachusetts | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Michigan | Occasionally | Monthly | Yes | No | Yes | Yes | Yes | Yes | No | No | No |
| Minnesota | Frequently | NR | NR | Yes | Yes | Yes | No | — | — | — | — |
| Mississippi | Occasionally | Quarterly | No | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Missouri | Occasionally | Weekly or biweekly | No[3] | No | Yes | No | Yes | No | Yes | Yes | Yes |
| Montana | Occasionally | As needed | Yes | No | Yes | No | Yes | Yes | Yes | Yes | No |
| Nebraska | Frequently | As needed | Yes | Yes | Yes | No | Yes | No | Yes | No | No |
| Nevada | Occasionally | Weekly or biweekly | Yes | Yes | Yes | Yes | No | — | — | — | — |
| New Hampshire | Occasionally | Monthly | No | No | NR | Yes | Yes | No | Yes | No | No |

See notes at end of table.

*Continued*

Table 7: Collaboration, *continued*

| State | How often do the Medicaid and mental health agencies collaborate? | How often are there regularly scheduled meetings between staff at the two agencies? | Directors of the two agencies have regularly scheduled meetings | Medicaid staff member who is the point person on mental health issues | Medicaid agency is represented on State mental health planning council | Medicaid agency participates in development of mental health plan | Mental Health Representation on MCAC | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | At least one slot reserved for mental health representative on MCAC[1] | Type of Representative | | | |
| | | | | | | | | Consumer | Provider | Mental health department | Other |
| **Total** | | | **34** | **37** | **42** | **36** | **32** | **12** | **22** | **12** | **6** |
| New Jersey | Somewhat Regularly | As needed | Yes | Yes | Yes | Yes | No | — | — | — | — |
| New Mexico | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| New York | Occasionally | Monthly[4] | Yes | Yes | Yes | Yes | No | — | — | — | — |
| North Carolina | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | No | — | — | — | — |
| North Dakota | Frequently | As needed | Yes | No | Yes | Yes | No | — | — | — | — |
| Ohio | Frequently | Weekly or biweekly | Yes | Yes | Yes | No | No | — | — | — | — |
| Oklahoma | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Oregon | Frequently | Monthly | Yes | No | No | No | Yes | No | Yes | No | No |
| Pennsylvania | Frequently | As needed | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Rhode Island | Somewhat Regularly | As needed | Yes | No | Yes | Yes | No | — | — | — | — |
| South Carolina | Frequently | Quarterly | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | No |
| South Dakota | Occasionally | As needed | No | No | Yes | No | Yes | No | No | No | Yes |
| Tennessee | Somewhat Regularly | Monthly | Yes | Yes | Yes | Yes | Yes | No | No | No | Yes |
| Texas | Frequently | Monthly | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Utah | Somewhat Regularly | As needed | No | Yes | Yes | No | Yes | No | No | Yes | No |

See notes at end of table.

*Continued*

Table 7: Collaboration, *continued*

| State | How often do the Medicaid and mental health agencies collaborate? | How often are there regularly scheduled meetings between staff at the two agencies? | Directors of the two agencies have regularly scheduled meetings | Medicaid staff member who is the point person on mental health issues | Medicaid agency is represented on State mental health planning council | Medicaid agency participates in development of mental health plan | Mental Health Representation on MCAC | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | At least one slot reserved for mental health representative on MCAC[1] | Type of Representative | | | |
| | | | | | | | | Consumer | Provider | Mental health department | Other |
| **Total** | | | **34** | **37** | **42** | **36** | **32** | **12** | **22** | **12** | **6** |
| Vermont | Frequently | As needed | No | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Virginia | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Washington | Occasionally | Other | Yes | —[5] | Yes | Yes | No | — | — | — | — |
| West Virginia | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Wisconsin | Frequently | Weekly or biweekly | Yes | Yes | Yes | Yes | Yes | Yes | No | No | No |
| Wyoming | Somewhat Regularly | Weekly or biweekly | Yes | Yes | Yes | Yes | No | — | — | — | — |

NR = No response

[1] Medical care advisory committee.

[2] No State medical care advisory committee

[3] Directors meet occasionally, but meetings are not regularly scheduled.

[4] Bimonthly.

[5] Not necessary, since the Medicaid director also served as the mental health agency director at the time of the interview.

### 3. *Director Meetings*

Regularly scheduled meetings between the directors of the Medicaid and mental health agencies occur in 34 States. According to interviewees, directors tend to discuss larger policy issues, budgetary initiatives, services provided under waivers, and various compliance issues, while the agency staff meetings are more programmatic and administrative in nature. One reviewer of a draft of this report noted that regular meetings of agency directors may not necessarily facilitate significant Medicaid-mental health collaboration if they merely represent regular meetings of the executive staff of umbrella agencies. Of the 34 States reporting regular meetings of agency directors, 22 were States with Medicaid and mental health in the same umbrella agency.

### 4. *Advisory Activities*

Thirty-six States reported that the Medicaid agency participates in the development of the State Mental Health Plan. The Medicaid agency is represented on the State Mental Health Planning Council (MHPC) in 42 States, while fewer States (32) reserve a slot on the State Medicaid Medical Care Advisory Committee (MCAC) for a mental health representative. Even in States that reserve a slot, the State mental health agency does not necessarily participate; the slot was most frequently reserved for a mental health provider (in 22 States), followed by a consumer (12 States) or mental health agency representative (12 States).[19]

### 5. *Medicaid Point Person on Mental Health Issues*

Thirty-seven States have a Medicaid staff member who serves as the "point person" on mental health issues. The responsibilities of these individuals vary greatly, interviewees said, with some focusing exclusively on mental health and others having mental health issues as only one segment of the many areas under their purview. Interviewees generally saw this role as important to increased communication, knowledge, and cooperation between the two agencies.

### 6. *Mental Health Policy Working Groups*

Joint participation in formal and informal working groups is widespread, although Medicaid agencies are more likely to participate in groups formulating mental health policy than the reverse. Virtually every State (47) reported the existence of at least one formal or informal working group that provides advice or discusses issues surrounding Medicaid mental health policy. In the majority of cases (46 States), these groups include representatives from entities other than State agencies, such as community advocates or providers. Forty-four States reported which State agencies participate in a total of 60 State work groups (Table 8). In most cases (38 States), at least one work group has both Medicaid and mental health agency participation. For all 60 work groups, the most common participants are the Medicaid and mental health agencies, followed by the children and family services, substance abuse, juvenile justice, and social services agencies. In some States, other agencies such as transportation, housing, labor, or aging participate. On average, six State agencies participate in the work groups.

[19] These figures do not add up to 32 because some States reserve more than one slot for different types of mental health representatives.

## Table 8: Mental Health Policy Working Groups

| *Total Working Groups* | *60* |
|---|---|
| Mental health agency | 53 |
| Medicaid agency | 52 |
| Children and family services | 38 |
| Substance abuse agency | 33 |
| Juvenile justice agency | 25 |
| Social services agency | 25 |
| Health department | 22 |
| Education department | 21 |
| Disabilities agency | 21 |
| Special education | 16 |
| Corrections agency | 15 |
| Rehabilitation agency | 13 |
| Governor's office staff | 7 |
| Budget office staff | 6 |
| State legislative staff | 6 |
| Other agencies | 12 |

a. Examples of What Working Groups Do

A number of States have created working groups focused on integrating systems of care for children who receive services from multiple State agencies, particularly those in the foster care or juvenile justice systems. Some of these States gave the need to comply with the *Olmstead* decision as the reason for creating a work group to specifically address mental health service coordination for children.[20] In one State, the Medicaid and mental health agencies work together on several common projects, including efforts to bring (or keep) home those children currently sent out of the State for services. In another State, a steering committee was created with the intent of focusing on a population rather than a service structure. This committee is particularly valuable, the interviewee said, since the State's Medicaid and mental health agencies are no longer under the same umbrella organization. Now, the interviewee said, "When there are problems, we have a forum to talk about them," and each agency is able to go back and implement the agreed-upon solution.

Through one of its working groups, another State has created a protocol for children being removed from their homes. In such cases, the mental health agency is notified 24 hours prior to or within 24 hours of a child being removed, so that agency officials can contact the home and the child to provide services. This same State is working to bring mental health services into juvenile detention centers to serve children who may be "in limbo" between the two systems. In yet another State, the Medicaid and mental health agencies work together through a children's partnership to determine "how wisely [they] are spending [their State's] mental health dollars." The partnership pulls together utilization data to find where money is spent and to determine whether collaboration could reduce the duplication of services.

In several States, formal or informal interagency working groups meet regularly to discuss difficult individual cases, often instances when people fall through the cracks. These discussions can lead to changes in procedures, policies, and organizational structures to better address the larger problems highlighted by the specific cases.

[20] In *Olmstead* v. *L.C.*, 527 U.S. 581 (1999), the U.S. Supreme Court ruled that, under the 1990 Americans with Disabilities Act, States are required to place persons with mental disabilities in community settings rather than institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can reasonably be accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

The Medicaid director in one State underscored the importance of working on common problems by contrasting the State's differing experiences with child and adult mental health services. In this State, Medicaid funds services for almost all beneficiaries of the children's mental health agency. Because the State Medicaid agency regularly deals with the child mental health agency on many ongoing operational issues, these agencies have a very strong relationship. As the Medicaid director put it, "We're about as close as you can be without becoming the same agency." By contrast, the relationships between the Medicaid agency and the adult mental health agency are much more distant and wary, since Medicaid funds services for only 30 to 40 percent of the adult mental health agency's clients, and the adult service providers and advocacy groups tend to be somewhat suspicious of Medicaid.

## B. Some Patterns and Correlations

Not surprisingly, States reporting that their Medicaid and mental health agencies frequently collaborate on external projects also are more likely to hold regularly scheduled meetings, while States reporting less collaboration are more likely to hold meetings "as needed." More than half (54 percent) of all States where the agencies collaborate frequently hold weekly or biweekly meetings between staff at the agencies, while fewer than 13 percent of all States where agencies collaborate somewhat frequently or occasionally hold meetings that often. One-third of the States where collaboration is somewhat frequent or occasional report that the agencies hold meetings only "as needed," while only 19 percent of States that report frequent collaboration say they meet only as needed.

States where the Medicaid and mental health agencies frequently collaborate on external projects also are more likely to report that the Medicaid agency is represented on the MHPC (88 vs. 75 percent), participates in the development of the State Mental Health Plan (81 vs. 63 percent), and has a staff member as the point person on mental health issues (85 vs. 58 percent). These States also are more likely to report that the Medicaid agency reserves a slot for a mental health representative on the State MCAC (69 vs. 58 percent).

### *1. Impact of Agency Structure on Collaboration*

The structure of the Medicaid and mental health agencies within the State government correlates with the amount of reported internal and external collaboration (Figure 3). States where the Medicaid and mental health agencies are within the same umbrella agency are more likely to report frequent collaboration (57 vs. 43 percent), have directors who meet regularly (79 vs. 52 percent), have meetings between the agencies at least monthly (64 vs. 43 percent), and report Medicaid participation in the development of the State Mental Health Plan (82 vs. 57 percent). These States are only half as likely to report having an interagency agreement or memorandum of understanding, perhaps because such formal documents are less necessary when there is a common umbrella agency.

The structure of the agencies within the State government does not correlate with whether a slot is reserved for a mental health representative on the State MCAC. However, States where Medicaid and mental health are separate agencies were somewhat more likely to have a staff member serving as the point person on mental health issues within the Medicaid agency (78 vs. 68 percent) and to

**Figure 3: Organizational Structure and Collaboration Between Medicaid and Mental Health Agencies**

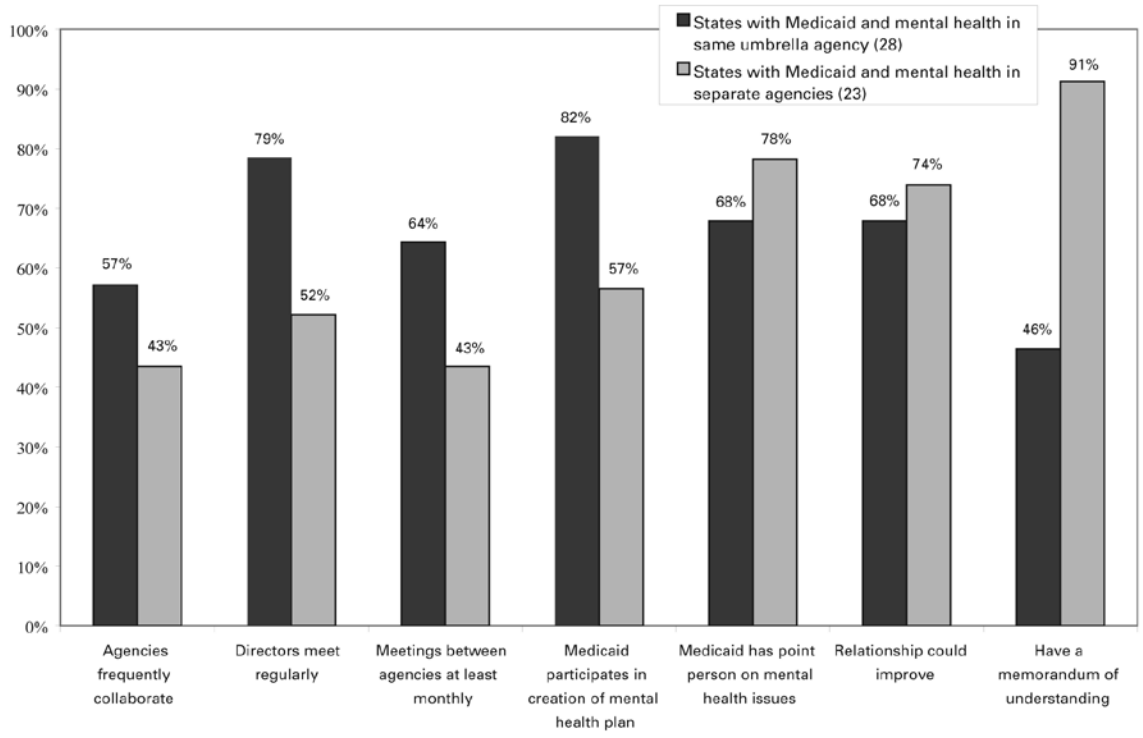
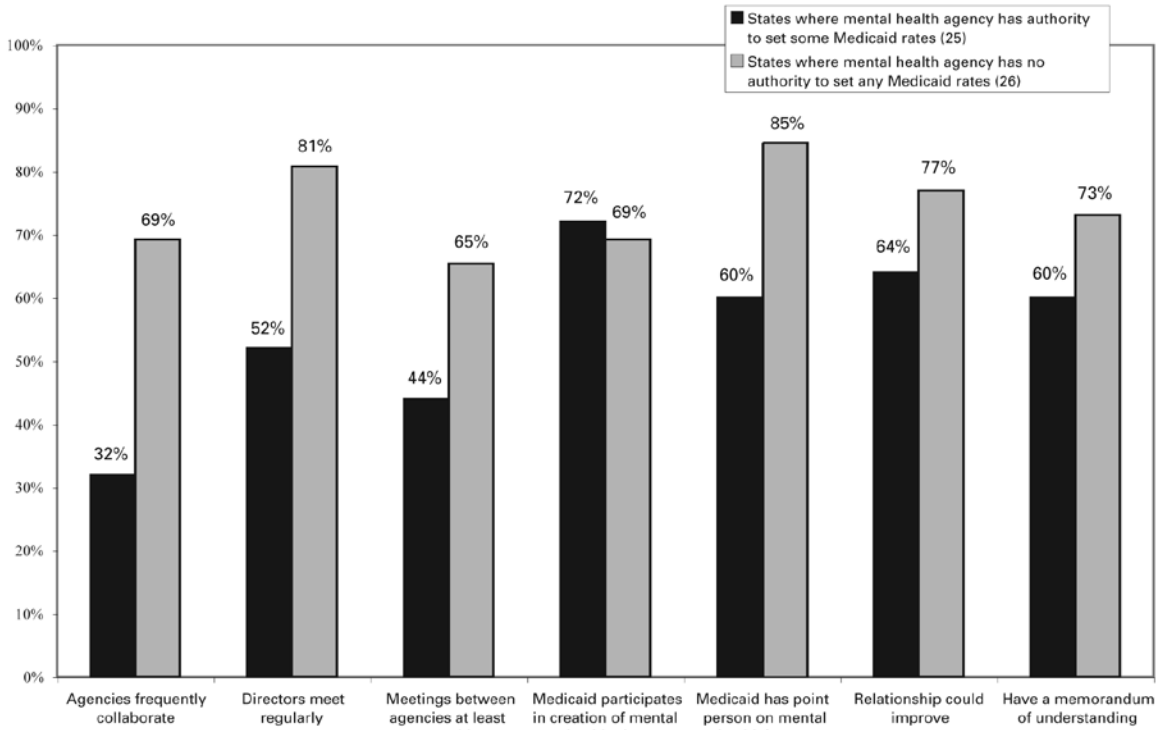



**Figure 4: Rate-setting Authority and Collaboration Between Medicaid and Mental Health Agencies**



have the Medicaid agency represented on the State MHPC (87 vs. 79 percent).

*2. Rate-Setting Authority and Collaboration*

States where the mental health agency has the authority to set rates for at least one Medicaid mental health service are less likely to report external or internal collaboration (Figure 4). Fewer than one-third (31 percent) of the States where the mental health agency has rate-setting authority reported frequent collaboration on external projects, while more than two-thirds (69 percent) of the States where the mental health agency does not have that authority report frequent collaboration. States where the mental health agency has rate-setting authority also are less likely to report regularly scheduled meetings between the agency directors (52 vs. 81 percent), or meetings at least monthly between the two agency's staffs (44 vs. 65 percent). A mental health agency with rate-setting authority also was less likely to report that the Medicaid agency has a staff member who serves as the point person on mental health issues (60 vs. 85 percent), that Medicaid is represented on the State MHPC (76 vs. 88 percent), or that a slot is reserved for a mental health representative on the State MCAC (56 vs. 69 percent). However, both for States where the mental health agency has rate-setting authority and for those that do not, there are roughly equal rates of Medicaid participation in the development of the Mental Health Plan (72 vs. 69 percent).

More than two-thirds of the respondents from all States said that the relationship between the Medicaid and mental health agencies could be improved. States that reported less frequent collaboration between the agencies and those in which the mental health agency has no authority to set any Medicaid mental health rates are more likely to think the relationship between the two agencies could be improved.

## C. Other Factors Affecting Collaboration

In addition to the factors affecting collaboration that were explicitly asked about in the survey, the interviews revealed a number of other factors that can have an impact on collaboration. They are summarized below.

*1. Staff Movement Between Agencies*

Many States noted that the movement of staff between the two agencies acts as another informal collaborative device. Examples were cited of States where separate Medicaid and mental health agencies were previously under the same umbrella agency and therefore very familiar with the each other, while others are currently located in the same agency. However, this route to collaboration is not always possible. One State respondent noted that movement between agencies is discouraged by separate merit and promotion systems. If employees from one agency transfer to the other, they have to start over in the merit system and, in effect, suffer a demotion.

*2. State and Agency Size*

Another variable that appears to influence the level of collaboration is the size of the State and the agencies within a State. As noted below, this relationship between State size and collaboration showed up more in the interviews than in the formal measures of collaboration reported in the survey. In many of the State interviews, the respondents from smaller agencies and less densely populated States reported a degree of informal collaboration that appeared to exceed that described by respondents from larger agencies and States. In some cases, the collaboration

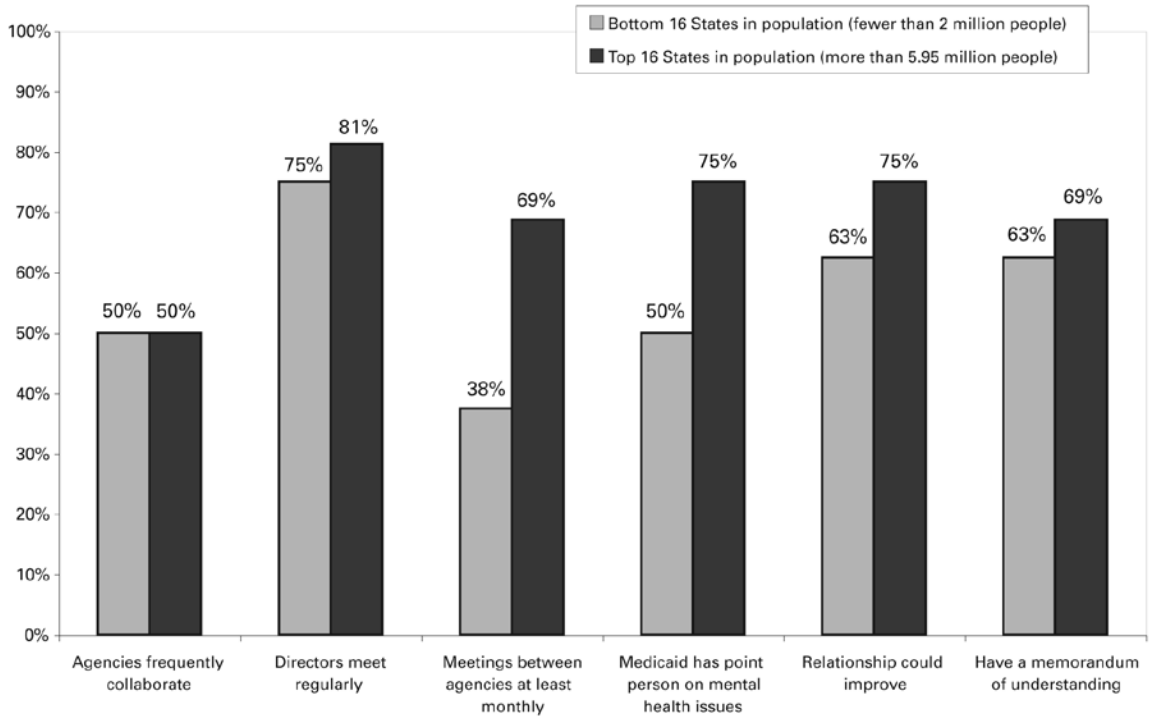
between the agencies is higher because of their physical office proximity, but more often than not this level of cooperation appears to be a product of their environment. One State respondent said, "Because we're a small State, we all know each other in terms of our entire lives." As a result, "we have relationships where [the Medicaid director can] just pick up the phone and work it out" if a problem arises. The respondent in another State said that the two agencies have an "excellent working relationship" because "we're a small handshake State." Another respondent from a small State said that because "everyone in this State knows everyone else," if there is a problem it will be addressed.

This relationship between collaboration and State size was difficult to quantify with the collaboration measures used in the survey, however. Small and large States were equally likely to report "frequent" collaboration, and the smaller States tend to have fewer formal mechanisms to facilitate that collaboration, as seen in Figure 5. One interpretation is that degrees of collaboration are context-specific, so that what looks like frequent collaboration in a large State may be viewed as just part of normal day-to-day business in a small State. It may also be the case that collaboration requires more formal mechanisms in large States than in small ones.

### *3. Personal Relationships*

While the formal devices used to maintain coordination between State mental health and Medicaid agencies are helpful in facilitating working relationships, States reported that most relationships are dictated by more informal mechanisms. As one respondent said, "The informal is just as important as the formal." This respondent added that when it comes to understanding how Medic-

**Figure 5: Collaboration Among States with Highest and Lowest Populations**



aid and mental health work together, much of their collaboration is based on personal relationships rather than formal structures. Numerous respondents noted that interagency relationships tend to fluctuate depending on the compatibility of the agency leaders. In one State, the Medicaid and mental health directors, participating jointly in the phone interview, emphasized their strong personal relationship by noting that they had had Thanksgiving dinner together. Although this example may not be typical, the importance of strong personal relationships between agency heads was echoed in many other State interviews.

One respondent put it succinctly by reporting that the agency leadership is "playing really well together right now. It's all about personalities, and right now it's good." A respondent from another State remarked that the relationship between the two agencies is "at an all-time high" but that things were a bit adversarial before the two current directors were in place. Similarly, the respondent from another State discussed the troubled relationship between the two agencies 4 years ago, but said that the current directors worked well together.

The survey results may actually understate the importance of these relationships, since none of the questions explicitly addressed this issue. One reviewer of a draft of the report noted that as Medicaid director he met fairly often with the mental health director in informal settings in which policy issues were discussed (breakfast, lunch, dinner), but he did not think of these as "regularly scheduled meetings" when responding to the survey question on meetings between agency heads.

#### *4. Federal Rules and Limitations*

Many respondents cited Federal Medicaid rules and limitations as important factors in relationships between State Medicaid and mental health agencies, noting that they could sometimes lead to heightened tensions between the two agencies.

## D. Summary

Slightly more than half of the respondents reported that the Medicaid and mental health agencies collaborate frequently through external meetings, public reports, or presentations to the legislature. In terms of internal collaboration, 17 States hold weekly or biweekly meetings between the staff of the Medicaid and mental health agencies, and 18 other States reported less frequent but still regularly scheduled meetings. Thirty-four States reported regularly scheduled meetings between the directors of the Medicaid and mental health agencies. Joint participation in formal work groups is widespread, although the Medicaid agency is more likely to participate in groups formulating mental health policy than the reverse. Several less formal factors affect collaboration, including staff movement between agencies, State and agency size, personal relationships, and Federal rules and limitations.

# IV. A Closer Look at Some Specific Types of States

As indicated in the preceding chapters, States have taken a variety of approaches to providing mental health services through Medicaid. The relationship between the Medicaid and mental health agencies and the degree of collaboration between them varies substantially from State to State. Some States make extensive use of the public mental health system to administer Medicaid mental health services, while others largely bypass the mental health system, choosing instead to treat mental health services in essentially the same way as physical health services within the Medicaid program.

This chapter uses the State characteristics and activities discussed in Chapters II and III to categorize States on two dimensions: by the level of collaboration between Medicaid and mental health agencies, and by the relative authority of these agencies with respect to Medicaid-funded mental health services. It then looks at additional characteristics that are associated with States that are at either end of the collaboration and authority spectrums and examines how these States deal with Medicaid managed care and other common issues and projects.

Looking at States that are at the ends of these spectrums can help to identify some of the strengths and limitations of different State approaches to dealing with Medicaid and mental health services. States that may want to move in different directions can see some of the potential implications of doing so and can look to specific States as models of where they might want to go or avoid going.

This chapter first describes the methodology that was used to classify States on the dimensions of collaboration and authority, and then it looks more closely at how specific States that fall on either end of the collaboration or authority spectrums deal with a variety of Medicaid mental health service issues. Since the classifications are designed to identify distinct State types, the majority of States (28) that fall closer to the middle of these two spectrums are not discussed in this chapter. In addition, as discussed further below, the measures used to classify States have inherent limitations, since a single survey cannot capture or give appropriate weight to all of the variables that may be relevant in each State or group of States.

## A. State Classifications

The State classifications were developed by using clusters of characteristics that indicate relatively higher or lower levels of collaboration and relatively higher or lower levels of Medicaid agency authority over Medicaid mental health services.

### *1. Collaboration*

First, five measures of "higher collaboration" and four measures of "lower collaboration" were identified, and States were ranked on them. The measures are formal indications of both internal and external collaboration between the Medicaid and State mental health agencies, as well as of data sharing between them. There are eight States where at least four of the five higher-collaboration measures were present and eight States where at least two of the four lower-collaboration measures and only one or fewer of the higher-collaboration measures were present. These States were designated the higher-collaboration and lower-collaboration States, respectively.

There were 35 States that did not score highly on either the higher- or lower-collaboration measures, so they were not designated as either higher- or lower-collaboration States.

**Limitations of the Collaboration Measures.** Since the survey did not explicitly ask respondents to characterize the overall degree of collaboration between Medicaid and mental health agencies in their State, and since respondents generally are not familiar enough with other States to rank themselves on this dimension, the measures outlined above are necessarily indirect and incomplete. They indicate whether some formal structures that could facilitate collaboration are in place and whether some specific kinds of collaborative activities have occurred, but they do not measure less formal activities such as ad hoc meetings or personal relationships between agency heads. In addition, since the survey respondents were primarily from the State Medicaid agency, a different picture of the degree of collaboration between Medicaid and mental health agencies in particular States might result if respondents from State mental health agencies were surveyed.

### *2. Authority*

Five measures, shown below, measure the extent to which States have delegated significant aspects of the administration of Medicaid mental health services to the mental health agency and are thus using the public mental health system to some extent to deliv-

| "Higher-Collaboration" Measures | "Lower-Collaboration" Measures |
|---|---|
| • Regular meetings between agency directors<br>• Meetings between agency staff either weekly or more often<br>• Self-reported "frequent" collaboration<br>• One or more "very influential" work groups in which both agencies participate<br>• Links between Medicaid and mental health data | • Meetings between staff at the two agencies either quarterly or less often<br>• Self-reported "occasional" collaboration<br>• Medicaid agency does not participate in the development of the State mental health plan<br>• Medicaid agency does not make MMIS data available to the mental health agency<br>• No more than one "higher-collaboration" measure is present |

er Medicaid services. States where few of these measures are present appear not to have delegated significant authority for mental health services to the public mental health system. The five States where all five measures of delegation of Medicaid authority to the mental health agency are present are classified as "lower Medicaid agency authority" States, while the four States where none of the measures is present are classified as "higher Medicaid authority" States.

Most States fell between the two ends of the authority spectrum. Closer to the "higher Medicaid authority" end of the continuum, there are 7 States where only one measure of delegated authority is present and 17 States where two of the five measures are present. Closer to the "lower Medicaid agency authority" end of the continuum, there are 5 States where four of the five measures of delegated authority are present and 13 States where three of the five measures are present.

**"Lower Medicaid Agency Authority" Measures**

- At least some funds for Medicaid mental health services come from a source different from other Medicaid funds
- Mental health providers are paid differently from other providers
- Mental health agency has authority to set more than one rate or sets the capitation rate for mental health services
- At least some mental health services or populations are carved out of regular Medicaid
- Mental health providers are certified or enrolled into Medicaid differently from other providers

### *3. Summary of Collaboration and Authority Classifications*

There were 23 States that could be classified as being on the higher or lower end of the collaboration or authority dimensions. In general, there did not appear to be a pattern between level of collaboration and the level of Medicaid authority. All States with lower Medicaid authority over mental health services were on neither the higher nor lower end of the collaboration spectrum; most States with higher Medicaid authority were also neither higher- nor lower-collaboration States, with only one higher-authority State also in the higher-collaboration category and one higher-authority State in the lower-collaboration category.

The 23 States that fell at the higher or lower end of the collaboration or authority dimensions were analyzed to explore whether they have other characteristics in common or may have opportunities to work together on specific issues or projects. Responses to the open-ended questions on the survey were used to obtain additional information on specific collaborative activities or opportunities. This analysis is detailed in the remainder of this chapter.

## B. States with Relatively Higher Levels of Medicaid-Mental Health Agency Collaboration

The eight States that were on the higher end of the collaboration dimension (Louisiana, Massachusetts, Nevada, New Mexico, North Carolina, Oklahoma, Pennsylvania, and Wisconsin) also have other features in common:

- The Medicaid and mental health agencies are in the same umbrella agency in six of the eight States.
- All scored highly on other measures of collaboration:

- The Medicaid agency participates in the development of the mental health plan in all eight States.
- A mental health slot is reserved on the Medicaid Advisory Committee in six of the States, and in two it is explicitly reserved for someone from the mental health agency.
- All eight States have a Medicaid staff person who is the point person for mental health.

- The mental health agency does not set Medicaid rates in any of the eight States

### *1. Managed Care for Medicaid-Funded Mental Health Services in Higher-Collaboration States*

Six of the eight States that scored on the higher end of the collaboration dimension provide some Medicaid mental health services through managed care arrangements: Massachusetts, Nevada, New Mexico, North Carolina, Pennsylvania, and Wisconsin. All six provide some mental health benefits through a BHO[21] or ASO, and all of them have some kind of Medicaid managed care program. Some mental health services or populations are carved out of general managed care programs in all of these States, with services provided in either the Medicaid fee-for-service program or through a BHO or ASO.

Two of the States (Louisiana and Oklahoma) do not use a BHO or ASO to provide mental health services and do not have any other kind of Medicaid managed care arrangement for mental health services or populations.

[21] Wisconsin has a BHO available only to children with serious emotional disturbances.

The process of designing, implementing, and managing various kinds of managed care programs may provide opportunities for the Medicaid and mental health agencies to work together and better understand each other's priorities and constraints. The survey did not explore this issue in depth, however, so it provides little direct evidence on the extent or nature of such collaboration.

Looking at all States nationwide, there is no difference in the formal measures of collaboration between States reporting the use of a BHO or ASO to provide mental health services and those that do not, but these formal measures do not capture all forms of collaboration, and BHOs and ASOs are not the only forms of managed care.

### *2. Other Common Issues and Projects*

In addition to managed care, some of these States have other major projects that provide opportunities for the agencies to work together. New Mexico, for example, has undertaken a major government reorganization aimed at coordinating all State-provided mental health services more effectively. The New Mexico Behavioral Health Purchasing Collaborative is a cross-agency work group that serves as an umbrella connecting all agencies and departments dealing with behavioral health. It was created to plan, design, and direct a statewide behavioral health system. The main Collaborative body is composed of the secretaries and directors of 17 State agencies and departments[22] who

[22] The departments include the Children, Youth, and Families Department; the Corrections Department; the Department of Health; the Department of Labor; the Department of Transportation; the Governor's Commission on Disability; the Human Services Department; and the Indian Affairs Department.

have decision-making authority regarding all department funding, staff, and activities. Functioning as a board of directors, the Collaborative oversees all behavioral health services spending across departments. The Collaborative negotiates with contractors; addresses issues relating to data, transportation, financing, policy, and workforce development; facilitates interagency transfers; and coordinates with the Local Collaborative Regional Teams to identify service needs. A wholly integrated system is expected by 2009, after a three-phase transformation.[23]

In North Carolina, a working group focuses on integrating mental health and physical health care for children. The group discusses policy changes, which then go to a physician advisory group prior to public comment. Nevada and Massachusetts have working groups focused primarily on Medicaid mental health redesign.

In Wisconsin, the mental health and Medicaid agencies work jointly on a statewide task force to educate people on mental health recovery, as well as on the State's SAMHSA mental health transformation grant.

## C. States with Relatively Lower Levels of Medicaid-Mental Health Agency Collaboration

The eight States that scored on the lower end of the collaboration dimension (Colorado, Delaware, the District of Columbia, Hawaii, Mississippi, Montana, South Dakota, and Utah) also have a number of features in common:

- The Medicaid and mental health agencies are under the same umbrella agency in only two of the eight States.
- The mental health agency certifies or enrolls Medicaid mental health providers in only one of the States.
- The mental health agency produces reports about Medicaid mental health services in only three of the States.
- Of the seven States where the Medicaid agency produces mental health reports, only two share those internal reports with the mental health agency.
- The directors of the Medicaid and mental health agencies do not meet regularly in four of the States, and in the other four the directors meet only in the context of larger meetings involving multiple agency heads or other staff.
- The lower-collaboration States tend to be smaller, with an average population of 1.8 million, compared to higher-collaboration States that have an average population of 5.7 million.

### *1. Managed Care for Medicaid-Funded Mental Health Services in Lower-Collaboration States*

There is relatively limited managed care for Medicaid-funded mental health services in these eight States, a fact that may be related to their relatively lower levels of collaboration. Without these managed care arrangements, there is one less occasion for collaborative work.

Only four of the eight States (Colorado, Delaware, Hawaii, and Utah) use a BHO or ASO to deliver mental health services. In three of these four States, at least some mental health services or populations are carved out of general Medicaid managed care

[23] For more details, see New Mexico Behavioral Health Purchasing Collaborative Executive Summary at http://www.state.nm.us/hsd/bhdwg/pdf/PurchCollExecSum.pdf.

programs and are provided in either fee-for-service Medicaid or through the BHO or ASO. The four other States do not use a BHO or ASO to deliver any mental health services. However, the District of Columbia does provide Medicaid physical and mental health services to Supplemental Security Income (SSI) children through a capitated managed care organization.

Three of the eight lower-collaboration States (Mississippi, Montana, and South Dakota) did not have any form of capitated comprehensive Medicaid managed care program as of June 2005 (CMS, 2005). In the Nation as a whole, only 15 States (30 percent) did not have such a program in mid-2005.

#### *2. Other Common Issues and Projects*

Only two of the eight States (Hawaii and Mississippi) reported that working groups are addressing specific problems common to Medicaid and mental health. Two of the States with working groups where both Medicaid and mental health agencies are represented (Delaware and Utah) reported that the groups generally do not focus on specific common problems. None of these four States reported that the working groups are "very influential."

The other four States either have no working groups (the District of Columbia and South Dakota), or have groups in which only the Medicaid agency (Colorado) or the mental health agency (Montana) participate. Since 47 States reported having Medicaid and/or mental health working groups, this was not used as a separate measure of collaboration. It is therefore worth noting that two of the four States without working groups also ranked lower on the collaboration dimension, further underscoring the apparent reduced level of collaboration in those States.

#### *3. Fragmentation of Responsibility*

It is also worth noting that four of the eight States with relatively lower levels of collaboration had at least some fragmentation of responsibility within the mental health agency:

- Three of the States (Delaware, Hawaii, and Montana) have more than one mental health agency.
- Utah has only one State mental health agency, but the Medicaid agency deals with a number of strong county-level mental health agencies more frequently than with the State agency, potentially creating a similar fragmentation problem.

### D. States with Relatively Higher Levels of Medicaid Agency Authority over Mental Health Services

The four States with relatively higher levels of Medicaid agency authority over Medicaid mental health services, and correspondingly lower mental health agency authority (Arkansas, North Dakota, Oklahoma, and South Dakota) have several other characteristics worth noting:

- The Medicaid and mental health agencies are under the same umbrella agency in only two of the four States.
- Only two of the four have regularly scheduled meetings monthly or more often, and only two of the four have directors who meet regularly.
- All four have a Medicaid staff member who acts as the "point person" on mental health policy within the Medicaid agency.
- None of the Medicaid agencies reported a line item for mental health services in the Medicaid budget, and in only one State

did the mental health agency fund Medicaid services.

- Three of the four States gave the mental health agency access to the MMIS, and one State reported that the Medicaid and mental health agencies linked client-level data.
- In two of the four States, the mental health agency produces reports on Medicaid mental health services.
- All four States had populations of less than 4 million.

One of these States is in the lower-collaboration category (South Dakota), and one is in the higher-collaboration category (Oklahoma). As noted earlier, these formal measures of collaboration may not account fully for the informal collaboration that can take place in smaller States. The seven States in this category of higher Medicaid agency authority have an average population of just 1.9 million, and the largest State has a population of 3.5 million, compared to a median State population of 4.2 million for all States.

#### *1. Managed Care for Medicaid-Funded Mental Health Services in States with Higher Medicaid Agency Authority*

Only one of the four States reported using a BHO or ASO to provide mental health services. In North Dakota, a commercial Medicaid managed care organization operating in three counties provides both mental and physical health services on a capitated basis to around 750 enrollees, or about 1.5 percent of the Medicaid population in the State.

#### *2. Other Common Issues and Projects*

North Dakota has a working group that meets primarily to discuss children's mental health issues, but it also serves as the default group when local and regional offices cannot solve problems in individual cases.

### E. States with Relatively Lower Levels of Medicaid Agency Authority over Mental Health Services

The five States in which the Medicaid agency has delegated relatively large amounts of authority for administration of Medicaid mental health services to the mental health agency (California, Michigan, Ohio, Oregon, and Washington) have several other characteristics worth noting:

- In four of the five States, the mental health agency is under the same umbrella agency as the Medicaid agency.
- Four of the five States hold meetings between Medicaid and mental health agency staff monthly or more often, and all five have regularly scheduled meetings between the directors of the two agencies.
- Only three of the five Medicaid agencies are represented on the State Mental Health Planning Council, and only two have a "point person" on mental health issues within the Medicaid program.
- Three of the five States have a line item for mental health services in the Medicaid budget, and the mental health agency funds Medicaid services in four States.
- All five States allowed the mental health agency to access the MMIS, although only one State had linked client-level data between Medicaid and mental health.
- In four of the five States, the mental health agency creates reports about Medicaid mental health data.
- These States tend to be larger, with an average population of 13.5 million, compared to the median State population of

4.2 million for all States, and three of the States have more than 10 million people.

#### *1. Managed Care for Medicaid-Funded Mental Health Services in States with Lower Medicaid Agency Authority*

Three of the five States (Michigan, Oregon, and Washington) reported using a BHO or an ASO to provide mental health services, and also reported that at least some mental health services or populations are carved out of general Medicaid managed care contracts. The other two States (California and Ohio) reported not using a BHO or ASO for mental health services.

In California, Medicaid mental health services are administered through the mental health agency and delivered by county mental health departments that act as mental health plans. All Medicaid mental health providers must be employees or contractors of the counties. In Washington, Medicaid mental health services are provided through managed care organizations called regional service networks (RSNs). Capitated payments to RSNs cover services to Medicaid eligibles through a county-based network of CMHCs and clinics. In Oregon, Medicaid mental health services are administered by nine mental health managed care organizations under an 1115 waiver.

#### *2. Other Common Issues and Projects*

Survey respondents cited relatively few specific examples of work on common projects in these States. Oregon and Michigan respondents mentioned that the Medicaid and mental health agencies are jointly examining psychotropic and/or substance abuse drug prescribing patterns.

## F. Some Patterns and Correlations

While the States with relatively lower levels of Medicaid authority over mental health services were not more likely to be on the higher-collaboration end than the lower-collaboration end of that spectrum, they were in a position to work together with the mental health agency (they were in the same umbrella agency in four of the five States), and there were more indicators of collaboration in these States (meetings, data sharing, funding) than in the States with relatively higher Medicaid agency authority. In addition, the fact that the Medicaid agency has delegated significant authority for administration of Medicaid mental health services to the mental health agency (one of the measures used to identify States with lower Medicaid authority) suggests that the public mental health system in these States has the infrastructure needed to handle this responsibility.

One of the notable characteristics of the States on the opposite ends of the relative Medicaid authority spectrum is the difference in average population sizes. Larger States appear to delegate more Medicaid authority to the mental health agency, perhaps reflecting the availability of a more well-developed public mental health system in those States. Several of the smaller States with relatively higher Medicaid agency authority, by contrast, said in the interviews that finding an adequate supply of mental health providers, particularly in rural areas, was a perennial problem, suggesting a less-developed public mental health system.

Data sharing and reporting was not strongly correlated with the level of relative authority. On both ends of the spectrum, most States gave the mental health agency access to the MMIS, but not many linked

client-level data between the Medicaid and mental health agencies.

## G. Summary

**Classification Methodology.** Eight States were classified as having relatively higher levels of collaboration between State Medicaid and mental health agencies and eight States as having relatively lower levels of collaboration, based on measures such as the number of regular meetings, self-reported frequency of collaboration, and sharing of data. Four States were classified as having relatively higher levels of Medicaid agency authority over Medicaid-funded mental health services and five States as having relatively lower Medicaid agency authority, based on measures such as responsibility for mental health services funding, rate setting, and provider certification.

One of the four States in which the Medicaid agency has delegated a relatively higher level of authority to the mental health agency was in the higher-collaboration category and one was in the lower-collaboration category, while none of the five States with relatively high Medicaid agency authority was in the higher- or lower-collaboration categories.

**Higher-Collaboration States.** The eight States in the higher-collaboration category are more likely to have Medicaid and mental health under the same umbrella agency. The mental health agency does not set Medicaid rates in any of these States. These States often have specific projects on which both agencies work, in some cases involving Medicaid managed care.

**Lower-Collaboration States.** The eight States in the lower-collaboration category are more likely to have Medicaid and mental health in separate agencies and less likely to have the mental health agency participate in the certification of mental health providers or issuing reports. These States often are characterized by a fragmentation of responsibility within the State mental health agency, as well as by few cross-agency working groups.

**States with Higher Medicaid Agency Authority.** In the four States in which the Medicaid agency has relatively higher authority over mental health services, the Medicaid and mental health agencies tend to operate separately in a number of ways (fewer meetings, less mental health funding of Medicaid services, separate agencies in two of the States). There is very little managed care in these States, and the populations are relatively small.

**States with Lower Medicaid Agency Authority.** The five States with relatively lower Medicaid agency authority over mental health services are more likely to have Medicaid and mental health under the same umbrella agency (four of the five) and are more likely to report several indicators of collaboration. Three of the five States reported using a BSO or ASO to provide Medicaid mental health services, and three of the States have very large populations.

# V. Summary and Conclusions

The survey of Medicaid directors conducted for this report represents a snapshot of Medicaid agency perspectives on Medicaid-funded mental health services in the latter half of 2005 and early 2006. Many new Governors took office in 2007, new Medicaid and mental health agency heads will be appointed, government reorganization will be on the agenda in many States, and Federal laws and regulations affecting Medicaid and mental health services will continue to be revised.

What is reported here about individual States will inevitably change and probably has done so already in many States. The broader patterns that have been identified also will change, although perhaps more slowly. What is clear from the report, however, is that States have a wide array of options for dealing with Medicaid-funded mental health services. What is likely to work best in an individual State inevitably will be a reflection of the history, current context, organizational structure, policy priorities, and leadership goals in that State. This report describes the Medicaid options States chose as of 2005 and provides a resource for future State decision making on these important issues.

## A. Summary

The increasingly important role that State Medicaid agencies have played in the administration of State mental health services reflects the steady growth over the last three decades in the share of public mental health services funded by Medicaid.

This shift in funding responsibilities and the addition of Federal Medicaid dollars has led in many cases to greater total funding of State mental health services than would otherwise have been possible. It has also led in some cases to tensions between Medicaid and mental health agencies as Medicaid agencies have sought to fit mental health services within Medicaid regulatory, funding, and program structures, while mental health agencies have sought to preserve the flexibility and clinical focus they believe is needed to provide mental health services most effectively.

SAMHSA commissioned the survey summarized in this report to learn more about the characteristics and implications of this growing Medicaid agency responsibility for mental health services. Some highlights from the survey and some of the patterns that emerged from analysis of the results are summarized below.

### *1. Organization, Funding, Services, Providers, and Managed Care*

In terms of **organizational structure**, State Medicaid and mental health agencies are in the same umbrella agency in 28 States and

are in separate agencies in 23 States. Seven States reported having more than one State-level mental health agency. In the vast majority of States, two or fewer reporting levels separate the Medicaid director from the Governor.

In terms of **funding**, the State match for Medicaid mental health services comes at least partially from the mental health agency in 32 States. In 22 States, some funding for Medicaid mental health services comes from counties or other local sources. In 23 States, the Medicaid agency has a separate line item in the budget for mental health services. In almost half the States, the mental health agency has the authority to set some Medicaid mental health rates, most commonly for residential treatment, psychiatric social workers, targeted case management, and psychosocial rehabilitation.

States were fairly consistent in their **definition of mental health services** for Medicaid funding purposes, with all States including outpatient services provided by psychiatric or designated mental health providers and more than 80 percent of States including services provided at community mental health centers (CMHCs), services provided under the rehabilitation option, inpatient services in a psychiatric hospital, and inpatient mental health services in a general hospital.

States tended to be somewhat restrictive in their **definition of mental health providers**, with 26 States requiring that providers have a mental health or psychiatric designation and 22 States requiring some or all Medicaid mental health providers to be enrolled or certified through the mental health agency.

Twenty-five States reported that at least some Medicaid mental health services or populations are covered through behavioral health organizations (BHOs) that provide services through a capitated **managed care** arrangement or through administrative services organizations (ASOs) that provide these services on a nonrisk fee-for-service basis. Of the 26 States that report not using a BHO or ASO, 12 carve out or exclude at least some mental health services or populations from broader Medicaid managed care programs. Only 10 States use none of these managed care arrangements.

### *2. Data and Reporting*

Forty States reported that the Medicaid agency produces formal reports that contain discrete data on mental health utilization or expenditures, including utilization and cost by service (29 States) and cost per beneficiary (26 States). In 27 States the mental health agency produced reports on Medicaid mental health spending or utilization. At least some of these reports are publicly available in 30 of the States, while in 7 States all reports are internal only.

Over three-quarters of the States make data from the Medicaid Management Information System (MMIS) available to the mental health agency for analysis. The data in the MMIS on Medicaid clients and services were linked at the client level to mental health agency client-level data in 16 States for either administrative or policy analysis purposes.

### *3. Collaboration Between Medicaid and Mental Health Agencies*

Slightly more than half of the States interviewed reported that the Medicaid agency and mental health agencies collaborate frequently through external meetings, public reports, or presentations to the legislature.

In terms of internal collaboration, 17 States hold weekly or biweekly meetings between the staff of the Medicaid and mental health agencies, and 18 other States reported

less frequent but still regularly scheduled meetings. Thirty-four States reported that there were regularly scheduled meetings between the directors of the Medicaid and mental health agencies.

Joint participation in formal work groups was widespread, although Medicaid was more likely to participate in groups formulating mental health policy than the reverse. Thirty-six States reported that the Medicaid agency participates in the development of the State Mental Health Plan, and 37 States have a Medicaid staff member who serves as the "point person" on mental health issues. A slot is reserved on the State Medicaid Medical Care Advisory Committee (MCAC) for a mental health representative in 32 States, but the slot was usually filled by a provider or a consumer representative rather than by a representative of the State mental health agency.

### *4. A Closer Look at Some Specific Types of States*

A number of States could be identified as outliers in terms of the degree of collaboration between Medicaid and mental health agencies or the relative authority of the two agencies over Medicaid-funded mental health services. The States on either end of these spectrums illustrate some of the characteristics and potential consequences of different approaches to Medicaid funding and administration of mental health services.

#### a. Higher-Collaboration States

Eight States ranked especially high on measures of Medicaid and mental health agency collaboration: Louisiana, Massachusetts, Nevada, New Mexico, North Carolina, Oklahoma, Pennsylvania, and Wisconsin. These States reported regular meetings between agency directors and staff, "frequent" collaboration, one or more "very influential" joint work groups, and linked Medicaid and mental health data.

These eight higher-collaboration States had some other characteristics worth noting, including having both agencies in the same umbrella agency in six States.

#### b. Lower-Collaboration States

There were eight States where collaboration between Medicaid and mental health agencies was relatively low, based on low frequency of staff meetings, low self-reported levels of collaboration, no Medicaid participation in development of the State mental health plan, no sharing of Medicaid data with the mental health agency, and the absence of measures of higher collaboration: Colorado, Delaware, the District of Columbia, Hawaii, Mississippi, Montana, South Dakota, and Utah.

These eight lower-collaboration States also had other characteristics worth noting, including having the two agencies in separate State agencies in six of the States, regular meetings between the agency directors in only four of the States, and limited mental health agency involvement in Medicaid mental health provider certification and use of Medicaid data.

#### c. States with Higher Medicaid Agency Authority

There were four States where the Medicaid agency appeared to have a relatively higher level of authority over Medicaid mental health services, based on limited mental health agency authority over Medicaid mental health rate setting and provider certification and limited mental health agency funding of Medicaid services: Arkansas, North Dakota, Oklahoma, and South Dakota.

These four States also had other characteristics worth noting, including having Medicaid and mental health in the same umbrella agency in only two of the States, having

fewer meetings and other indicators of collaboration, and smaller populations.

d. States with Lower Medicaid Agency Authority

There were five States in which the Medicaid agency appeared to have delegated a relatively high level of authority over Medicaid mental health services to the mental health agency, based on mental health agency authority over rate setting and provider certification and mental health funding of Medicaid services: California, Michigan, Ohio, Oregon, and Washington.

These five States had other characteristics worth noting, including having both agencies in the same umbrella agency (four of the five States), regular meetings of directors and staff, mental health agency funding of Medicaid services, and larger populations.

## B. Conclusions

As States consider their options for modifications in Medicaid agency responsibility for mental health services, some conclusions that emerge from analysis of the State survey responses may warrant special consideration.

### *1. Importance of Collaboration*

Collaboration between Medicaid and mental health agencies is important because of the steadily increasingly role that Medicaid is playing in financing mental health services in States. Medicaid agencies may not have the same level of clinical expertise and trust from mental health providers and beneficiaries as mental health agencies, and mental health agencies may not have a full understanding or appreciation of the regulatory and fiscal constraints under which Medicaid agencies must operate. It is important that both of these perspectives be reflected in State decision making and management with respect to Medicaid-funded mental health services.

The survey indicated that having both Medicaid and mental health agencies under the same umbrella agency is generally associated with collaboration, but that day-to-day operational factors such as meetings between agency directors and staff, common problems to work on, the priorities of agency leadership, and personal relationships between agency leaders and staff often are just as important and can facilitate or impede collaboration, whether the agencies themselves are in a common umbrella agency or are separate.

Funding and data-sharing arrangements also can facilitate or impede collaboration, but they tend to be a reflection of the collaboration that already exists or is being developed, rather than independent drivers of collaboration. With leadership support for collaboration between Medicaid and mental health agencies, the needed funding and data-sharing arrangements can be developed more readily. If leadership support is lacking, the existence of a funding and data-sharing infrastructure that facilitates collaboration generally is not sufficient to bring it about, except on fairly routine and low-visibility issues. Nonetheless, having this infrastructure in place can make collaboration more rapid and efficient if leadership support for such joint efforts develops.

### *2. Implications of County and Local Responsibility for Mental Health Services*

In a number of States, counties and other local governments have extensive responsibility for the administration and funding of mental health services. The implications of this for relationships between State Medicaid and mental health agencies and for Medicaid responsibility for Medicaid-funded mental health services could not be fully explored in the survey, given the complexity and State-

specific nature of these State-local relationships. However, the interviews conducted in States with significant local responsibility for mental health services made it clear that any modifications in State-level authority or funding for mental health services in such States must take into account the ramifications of these changes for local levels of government.

### *3. Implications for Reorganizations and Work on Common Problems*

The survey indicated that, with few exceptions, reorganizations of State government are not driven primarily by concerns over relationships between Medicaid and mental health. Given the growing importance of those relationships, however, and the organizational and management options available to facilitate greater collaboration between Medicaid and mental health agencies, more explicit attention to these options may be appropriate when States are considering reorganizations.

Similarly, States facing policy decisions about issues where Medicaid and mental health responsibility and expertise overlap—such as Medicaid managed care coverage of mental health services, or design and management of services for children with behavioral health problems or adults with both mental and physical disabilities—can build on the experience of other States that have made effective use of Medicaid and mental health working groups to deal with such issues.

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# Appendix A

# Additional State-by-State Tables

## Table A.1: Medicaid Mental Health Services and Spending

| State | The mental health agency sets Medicaid rates for some Medicaid mental health services | Which services? | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Residential treatment | Psychiatric social workers | Targeted case management | Psychosocial rehabilitation | Partial day treatment | Outpatient hospital services | Mental health clinic | Services of other licensed professionals | Physician services | Clinical psychologists | Family support services | Individual, group, or family therapy | Respite care | School-based services | Home- and community-based services | Inpatient mental health—general hospital | Inpatient mental health—psychiatric hospital |
| **Total** | **25** | **17** | **13** | **16** | **15** | **16** | **9** | **16** | **10** | **7** | **8** | **10** | **8** | **10** | **7** | **9** | **6** | **4** |
| Alabama | Yes | Yes | Yes | Yes | Yes | Yes | No | No | No | No | No | No | No | No | Yes | No | No | No |
| Alaska | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | No | Yes | No | No | No | No |
| Arizona | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes |
| Arkansas | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| California | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | No | No | Yes | Yes |
| Colorado | Yes | No | No | No | No | No | No | Yes | No | No | No | No | No | No | No | No | No | No |
| Connecticut | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Delaware | Yes | Yes | No | No | Yes | No | No | No | Yes | No | No | No | No | No | No | No | Yes | No |
| District of Columbia | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Florida | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Georgia | Yes | Yes | Yes | Yes | No | Yes | No | Yes | No | No | No | No | No | No | Yes | No | No | No |
| Hawaii | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Idaho | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Illinois | Yes | No | No | No | No | No | No | Yes | No | No | No | No | No | No | No | No | No | No |
| Indiana | Yes | No | No | No | No | No | No | No | No | No | No | No | No | No | No | Yes | No | No |
| Iowa | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Kansas | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | No | No | Yes | Yes | Yes | No | Yes | No | No |
| Kentucky | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Louisiana | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |

See notes at end of table.

*Continued*

Table A.1: Medicaid Mental Health Services and Spending, *continued*

| | | Which services? | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **State** | **The mental health agency sets Medicaid rates for some Medicaid mental health services** | **Residential treatment** | **Psychiatric social workers** | **Targeted case management** | **Psychosocial rehabilitation** | **Partial day treatment** | **Outpatient hospital services** | **Mental health clinic** | **Services of other licensed professionals** | **Physician services** | **Clinical psychologists** | **Family support services** | **Individual, group, or family therapy** | **Respite care** | **School-based services** | **Home- and community-based services** | **Inpatient mental health—general hospital** | **Inpatient mental health—psychiatric hospital** |
| **Total** | **25** | **17** | **13** | **16** | **15** | **16** | **9** | **16** | **10** | **7** | **8** | **10** | **8** | **10** | **7** | **9** | **6** | **4** |
| Maine | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Maryland | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No | No |
| Massachusetts | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Michigan | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No | No | No | Yes | Yes | No | No | Yes | Yes | Yes |
| Minnesota | Yes | No | Yes | Yes | No | Yes | No | Yes | No | No | No | Yes | No | Yes | No | No | Yes | No |
| Mississippi | Yes | No | No | Yes | Yes | Yes | No | Yes | No | No | No | No | Yes | No | Yes | No | No | No |
| Missouri | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Montana | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | No | No | No |
| Nebraska | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Nevada | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| New Hampshire | Yes | Yes | No | No | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | No | No | Yes | No |
| New Jersey | Yes | No | Yes | No | No | Yes | No | Yes | No | No | No | No | No | No | No | Yes | No | No |
| New Mexico | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| New York | Yes | Yes | No | Yes | Yes | Yes | No | Yes | No | No | No | Yes | Yes | Yes | No | Yes | No | Yes |
| North Carolina | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| North Dakota | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Ohio | Yes | Yes | No | Yes | No | No | No | No | No | Yes | Yes | No | No | No | No | No | No | No |
| Oklahoma | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Oregon | Yes | Yes | No | No | No | No | Yes | Yes | No | No | No | No | No | No | No | No | No | No |

See notes at end of table.

*Continued*

Table A.1: Medicaid Mental Health Services and Spending, *continued*

| | | Which services? | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **State** | **The mental health agency sets Medicaid rates for some Medicaid mental health services** | **Residential treatment** | **Psychiatric social workers** | **Targeted case management** | **Psychosocial rehabilitation** | **Partial day treatment** | **Outpatient hospital services** | **Mental health clinic** | **Services of other licensed professionals** | **Physician services** | **Clinical psychologists** | **Family support services** | **Individual, group, or family therapy** | **Respite care** | **School-based services** | **Home- and community-based services** | **Inpatient mental health—general hospital** | **Inpatient mental health—psychiatric hospital** |
| **Total** | **25** | **17** | **13** | **16** | **15** | **16** | **9** | **16** | **10** | **7** | **8** | **10** | **8** | **10** | **7** | **9** | **6** | **4** |
| Pennsylvania | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Rhode Island | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | No | Yes | No | No | Yes | No | No | No | No |
| South Carolina | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| South Dakota | Yes | No | No | No | No | No | No | No | No | No | No | No | No | No | No | Yes | No | No |
| Tennessee | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Texas | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Utah | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Vermont | Yes | Yes | No | Yes | Yes | No | No | Yes | No | No | No | No | No | Yes | Yes[1] | Yes | No | Yes[2] |
| Virginia | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Washington | Yes | No | No | No | No | No | No | No | No | No | No | No | No | No | No | Yes | No | No |
| West Virginia | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Wisconsin | No | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — |
| Wyoming | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No | Yes | No | No | No | No | No | No |

[1] Mental health centers contract with specific schools to provide some mental health services (not including special education).
[2] Rates are set by both mental health and Medicaid agencies.

Table A.2: Services Defined as Medicaid Mental Health Services for Rate-setting or State Budgeting Purposes

| *State* | *Inpatient mental health services in a general hospital* | *Inpatient mental health services in a psychiatric hospital* | *Outpatient services at community mental health centers* | *Outpatient services provided by psychiatric or designated mental health providers* | *Outpatient mental health services provided by a general or family physician* | *Psychotropic drugs* | *Services provided under the rehab option* | *Other services* |
|---|---|---|---|---|---|---|---|---|
| **Total** | **43** | **46** | **49** | **49** | **31** | **39** | **46** | **25** |
| Alabama | Yes | Yes | Yes | Yes | No | Yes | Yes | No |
| Alaska | No | Yes | Yes | Yes | Yes | No | Yes | No |
| Arizona | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Arkansas | Yes | Yes[1] | Yes | Yes | Yes | Yes | Yes | Yes |
| California | Yes | Yes | Yes | Yes | No | No | Yes | Yes |
| Colorado | Yes | Yes | Yes | Yes | Yes | Other[2] | Yes | Yes |
| Connecticut | Yes | Yes | Yes | Yes | No | No | Yes | Yes |
| Delaware | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| District of Columbia | No | Yes | Yes | Yes | No | Yes | Yes | No |
| Florida | Yes | Yes | Yes | Yes | No | No | Yes | No |
| Georgia | Yes | No | Yes | Yes | Yes | Yes | Yes | No |
| Hawaii | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Idaho | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Illinois | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Indiana | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Iowa | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Kansas | Yes | Yes | Yes | Yes | No | Yes | Yes | No |
| Kentucky | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Louisiana | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Maine | No | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Maryland | No | No | Yes[3] | Yes[3] | No | No | Yes[3] | No |
| Massachusetts | Yes | Yes | Yes | Yes | No | No | No | Yes |

See notes at end of table.

*Continued*

Table A.2: Services Defined as Medicaid Mental Health Services for Rate-setting or State Budgeting Purposes, *continued*

| *State* | *Inpatient mental health services in a general hospital* | *Inpatient mental health services in a psychiatric hospital* | *Outpatient services at community mental health centers* | *Outpatient services provided by psychiatric or designated mental health providers* | *Outpatient mental health services provided by a general or family physician* | *Psychotropic drugs* | *Services provided under the rehab option* | *Other services* |
|---|---|---|---|---|---|---|---|---|
| **Total** | **43** | **46** | **49** | **49** | **31** | **39** | **46** | **25** |
| Michigan | Yes | Yes | Yes | Yes | No | No | Yes | Yes |
| Minnesota | Yes | No | Yes | Yes | No | Yes | Yes | NR |
| Mississippi | Yes | Yes[1] | Yes | Yes[4] | Other[5] | Yes | Yes | Yes |
| Missouri | Yes | Yes[1] | Yes | Yes | Yes | Yes | Yes[6] | Yes |
| Montana | Yes | Yes[1] | Yes | Yes | Yes | Yes | Yes | Yes |
| Nebraska | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Nevada | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| New Hampshire | Yes | No | Yes | Yes | Yes | Yes | Yes | No |
| New Jersey | No | Yes | Yes | Yes[7] | No | No | Yes | No |
| New Mexico | Yes | Yes | Yes | Yes | No | No | Yes | Yes |
| New York | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| North Carolina | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| North Dakota | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Ohio | Yes | No | No | Yes | Yes | Yes | No | No |
| Oklahoma | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Oregon | Yes | Yes | Yes | Yes | No | Other | Other | NR |
| Pennsylvania | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes |
| Rhode Island | Yes | Yes | Yes | Yes[8] | Yes | Yes | Yes | Yes |
| South Carolina | No | Yes[1] | Yes | Yes[1] | No | Yes | Yes | No |
| South Dakota | Yes | Yes | No | Yes | Yes | Yes | No | No |
| Tennessee | Yes | Yes | Yes | Yes | Yes | Yes | Yes | NR |

See notes at end of table.

*Continued*

Table A.2: Services Defined as Medicaid Mental Health Services for Rate-setting or State Budgeting Purposes, *continued*

| State | Inpatient mental health services in a general hospital | Inpatient mental health services in a psychiatric hospital | Outpatient services at community mental health centers | Outpatient services provided by psychiatric or designated mental health providers | Outpatient mental health services provided by a general or family physician | Psychotropic drugs | Services provided under the rehab option | Other services |
|---|---|---|---|---|---|---|---|---|
| **Total** | **43** | **46** | **49** | **49** | **31** | **39** | **46** | **25** |
| Texas | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Utah | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes |
| Vermont | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Virginia | Yes | Yes | Yes | Yes | No | Yes | Yes | NR |
| Washington | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| West Virginia | No | Yes | Yes | Yes | No | No | Yes | No |
| Wisconsin | Yes | Yes | Yes | Yes | No | No | Yes | Yes |
| Wyoming | Other[9] | Yes[1] | Yes | Yes | Yes | Yes | Yes | Yes |

NR = No response

[1] Up to age 21.

[2] Psychotropic drugs are covered medical services. However, antipsychotic drugs are reported separately as mental health services for informational purposes.

[3] The State mental health authority administers all Medicaid mental health services and sets all rates.

[4] 12 visits per year.

[5] General physicians are not allowed to bill for psychological services.

[6] For some services.

[7] Only psychologists and community mental health clinics.

[8] Adults are limited to psychiatrist, hospital outpatient, or community mental health center.

[9] Acute stabilization only.

## Table A.3: Managed Care

| *State* | *State contracts with a BHO or an ASO for mental health service delivery*[1] | *Mental health services or populations carved out of managed care* |
|---|---|---|
| ***Total*** | ***26*** | ***34*** |
| Alabama | No | Other[2] |
| Alaska | No | Other[2] |
| Arizona | Yes | Yes |
| Arkansas | No | No |
| California | No | Yes |
| Colorado | Yes | Yes |
| Connecticut | Yes[3] | Yes |
| Delaware | Yes | No |
| District of Columbia | No | Yes |
| Florida | Yes | Yes |
| Georgia | Yes | Yes |
| Hawaii | Yes | Yes |
| Idaho | No | No |
| Illinois | No | No |
| Indiana | No | Yes |
| Iowa | Yes | Yes |
| Kansas | No | Yes |
| Kentucky | No | Yes |
| Louisiana | No | No |
| Maine | No | No |
| Maryland | Yes | Yes |
| Massachusetts | Yes | Yes[4] |
| Michigan | Yes | Yes |
| Minnesota | No | No |
| Mississippi | No | Other[2] |
| Missouri | Yes | Yes |
| Montana | No | No |
| Nebraska | Yes | Yes |
| Nevada | Yes | Yes |
| New Hampshire | No | No |
| New Jersey | No | Yes |
| New Mexico | Yes | Yes |
| New York | No | Yes |
| North Carolina | Yes | Yes |
| North Dakota | Yes[5] | No |
| Ohio | No | Yes |
| Oklahoma | No | No |

See notes at end of table.

*Continued*

## Table A.3: Managed Care, *continued*

| *State* | *State contracts with a BHO or an ASO for mental health service delivery*[1] | *Mental health services or populations carved out of managed care* |
|---|---|---|
| ***Total*** | ***26*** | ***34*** |
| Oregon | Yes | Yes |
| Pennsylvania | Yes | Yes |
| Rhode Island | Yes | Yes |
| South Carolina | No | Yes |
| South Dakota | No | No |
| Tennessee | Yes | No |
| Texas | Yes | Yes |
| Utah | | Yes |
| Vermont | Yes[6] | Yes[6] |
| Virginia | No | Yes[7] |
| Washington | Yes[8] | Yes |
| West Virginia | Yes | Yes |
| Wisconsin | No | Yes |
| Wyoming | No | Other[2] |

[1] Behavioral managed care organization (BHO) or administrative services organization (ASO).

[2] Not applicable; no Medicaid managed care for any services in the State.

[3] For Family Medicaid only.

[4] Mental health services are carved out of the primary care case management program but not carved out of the fully capitated managed care program.

[5] Behavioral and physical health covered by one managed care organization.

[6] The Medicaid agency contracts with the mental health agency to provide care to adults with severe persistent mental illness, who are carved out of primary care case management.

[7] Outpatient services are provided by managed care organizations, while mental health rehab services are carved out.

[8] The State contracts with regional support networks, which in turn subcontract with BHOs.

## Table A.4: Data

| State | MMIS Data Usage | | | Medicaid Linked Client Datasets | | | |
|---|---|---|---|---|---|---|---|
| | Data used by any agency for…. | | | Medicaid has linked client datasets with other agencies | Which agencies? | | |
| | Analysis of mental health service utilization | Linking to client-level data for administrative purposes | Linking to client-level data for policy analysis | | Children, family, and social services[1] | Mental health | Other[2] |
| **Total** | **40** | **34** | **32** | **25** | **15** | **16** | **15** |
| Alabama | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Alaska | Yes | Yes | Yes | No | — | — | — |
| Arizona | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Arkansas | Yes | NR | NR | NR | NR | NR | NR |
| California | Yes | Yes | Yes | Yes | Yes | No | No |
| Colorado | Yes | NR | NR | No | — | — | — |
| Connecticut | NR | NR | NR | No | — | — | — |
| Delaware | No | No | NR | Yes | Yes | No | No |
| District of Columbia | No | No | No | Yes | Yes | No | No |
| Florida | Yes | Yes | Yes | No | — | — | — |
| Georgia | Yes | Yes | Yes | No | — | — | — |
| Hawaii | NR | NR | NR | No | — | — | — |
| Idaho | NR | NR | NR | NR | NR | NR | NR |
| Illinois | NR | NR | NR | NR | NR | NR | NR |
| Indiana | Yes | No | No | No | — | — | — |
| Iowa | Yes | No | Yes | No | — | — | — |
| Kansas | Yes | Yes | Yes | No | — | — | — |
| Kentucky | NR | NR | NR | No | — | — | — |
| Louisiana | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Maine | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Maryland | Yes | Yes | Yes | No | — | — | — |
| Massachusetts | Yes | Yes | Yes | No | — | — | — |
| Michigan | Yes | Yes[3] | Yes[3] | No | — | — | — |
| Minnesota | Yes | Yes | No | No | — | — | — |
| Mississippi | Yes | Yes | No | No | — | — | — |
| Missouri | Yes | Yes | Yes | Yes | No | Yes | No |
| Montana | Yes | Yes | Yes | Yes | No | No | Yes |
| Nebraska | Yes | Yes | No | Yes | Yes | No | Yes |
| Nevada | NR | NR | NR | Yes | Yes | Yes | No |
| New Hampshire | Yes | Yes | Yes | No | — | — | — |

See notes at end of table.

*Continued*

Table A.4: Data, *continued*

| State | MMIS Data Usage | | | Medicaid Linked Client Datasets | | | |
|---|---|---|---|---|---|---|---|
| | Data used by any agency for…. | | | Medicaid has linked client datasets with other agencies | Which agencies? | | |
| | Analysis of mental health service utilization | Linking to client-level data for administrative purposes | Linking to client-level data for policy analysis | | Children, family, and social services[1] | Mental health | Other[2] |
| **Total** | **40** | **34** | **32** | **25** | **15** | **16** | **15** |
| New Jersey | NR | NR | NR | Yes | Yes | No | No |
| New Mexico | Yes[4] | Yes[4] | Yes[4] | Yes | Yes | No | Yes |
| New York | Yes | Yes | Yes | No | — | — | — |
| North Carolina | Yes | No | No | Yes | No | Yes | No |
| North Dakota | Yes | No | No | No | — | — | — |
| Ohio | Other[5] | Other[5] | Other[5] | No | — | — | — |
| Oklahoma | Yes | Yes | Yes | Yes | No | Yes | No |
| Oregon | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Pennsylvania | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Rhode Island | Yes | Yes | Yes | No | — | — | — |
| South Carolina | Yes | Yes | Yes | Yes | No | Yes | Yes |
| South Dakota | Yes | Yes | Yes | No | — | — | — |
| Tennessee | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Texas | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Utah | Yes | Yes | Yes | No | — | — | — |
| Vermont | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Virginia | NR | NR | NR | Yes | Yes | No | No |
| Washington | Yes | Yes | Yes | Yes | No | No | Yes |
| West Virginia | Yes | Yes | Yes | No | — | — | — |
| Wisconsin | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Wyoming | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

NR = No response

[1] Includes both children and family services and the social services agencies in each State.

[2] Includes corrections, education, health, substance abuse, Governor's office, budget office, and/or State legislative staff.

[3] Beginning to occur.

[4] Using on a limited basis.

[5] State mental health authority has its own claims database.

# Appendix B

## Expert Panel on Medicaid Mental Health Services—Program and Analytic Reports

## January 8, 2004

### Panel Members:

- Barry Brauth, New York State Office of Mental Health
- Michael Deily, Utah Department of Health
- Dick Dougherty, Dougherty Management Associates, Inc.
- Barbara Edwards, Office of Ohio Health Plans
- John Folkemer, Maryland Department of Health and Mental Hygiene
- George Gintoli, South Carolina Department of Mental Health
- Sherry Glied, Mailman School of Public Health, Columbia University
- Laura Lee Hall, National Association for the Mentally Ill Policy Research Institute
- Jim Hawthorne, Centers for Medicare and Medicaid Services (CMS)
- Chuck Ingoglia, National Mental Health Association (NMHA)
- Kathryn Kotula, National Association of State Medicaid Directors (NASMD)
- Noel Mazade, National Association of State Mental Health Program Directors Research Institute, Inc.
- Sandra Naylor-Goodwin, California Institute of Mental Health
- David Shern, Louis de la Parta Florida Mental Health Institute, University of South Florida
- Judy Stange, National Association of Mental Health Planning and Advisory Councils

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